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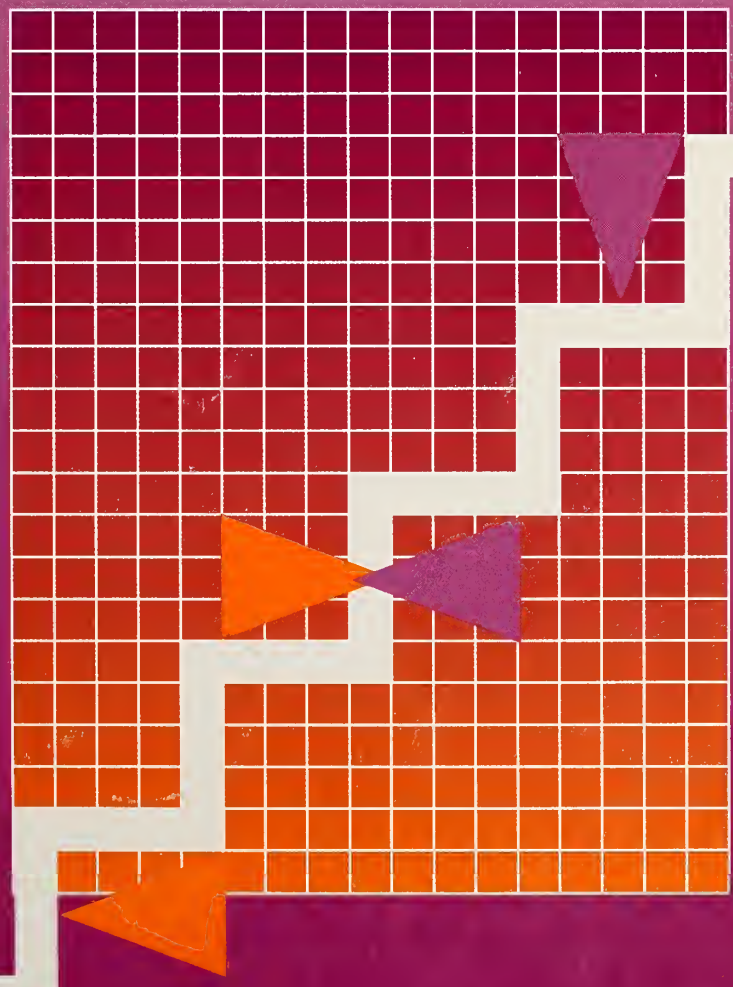
Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools



National Institutes of Health

National Institute on Drug Abuse

Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools

U.S. Department of Health and Human Services
National Institutes of Health

National Institute on Drug Abuse
Office of Science Policy and Communications
Public Information Branch
5600 Fishers Lane
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ACKNOWLEDGMENTS

This resource manual was developed by Abt Associates Inc. under Contract Number 271-90-2200 with the National Institute on Drug Abuse (NIDA). It was written by Karol L. Kumpfer, Ph.D.; Henry O. Whiteside, Ph.D.; Abraham H. Wandersman, Ph.D.; members of the Drug Control Policy Group, Bethesda, Maryland; and Elaine Cardenas, M.B.A., of Abt Associates Inc. Substantial technical editing was provided by Regina F. Berg, M.S.W., M.B.A., Project Director for the contract. Gerald P. Soucy, Ph.D., the NIDA Project Officer for the contract, offered many useful and substantive comments throughout the preparation of this manual.

The assistance of the many service providers who participated in the field testing of this material in Little Rock, Arkansas; and Albuquerque, New Mexico is gratefully acknowledged.

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National Institute on Drug Abuse
NIH Publication No. 97-4111
Printed 1997

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HOW TO USE THE DRUG ABUSE PREVENTION RESEARCH DISSEMINATION AND APPLICATIONS MATERIALS

Despite the best efforts of the Federal, State, and local governments, drug abuse continues to pose serious threats to the health, and social and economic stability of American communities. The causes of and factors associated with drug abuse are complex and vary across different segments of the population. To be effective, prevention programs must address not only the substance abuse behavior itself but also the relevant cultural, ethnic, regional, and other environmental and biopsychosocial aspects of the population segments being targeted for the prevention efforts. Therefore, it is important to match the program with the population it is to serve and the local community context within which it is to be implemented. The challenge for prevention practitioners is to select, modify, or design prevention strategies that will meet the needs of their constituencies, whether they comprise a whole community or specific segments within a community.

The Drug Abuse Prevention Research Dissemination and Applications (RDA) materials, of which this resource manual is a part, are designed to help practitioners plan and implement more effective prevention programs based on evidence from research about what works. These materials provide practitioners with the information they need to prepare their communities for prevention programming and to select and implement substance abuse prevention strategies that effectively address the needs of their local communities. These materials are intended for use by prevention practitioners who vary in their training and experience in the field but who are interested in developing prevention programs in their communities. The target audience for these documents includes prevention program administrators, prevention specialists, community volunteers, community activists, parents, teachers, counselors, and other individuals who have an interest in drug abuse and its prevention.

This resource manual, *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*, introduces the concept of community readiness for substance abuse prevention programming. The manual defines community readiness and provides a rationale for assessing a community's readiness prior to the planning or implementation of substance abuse prevention activities. It then identifies seven factors for assessing a community's readiness and offers strategies for increasing readiness factors found to be deficient. In addition to this resource manual, the core set of materials also includes three other documents:

- A *brochure* describes the contents of this set of RDA materials and provides information about how prevention practitioners can obtain these materials.

- *Drug Abuse Prevention: What Works* is an introductory handbook that provides an overview of the theory and research on which these materials are based. It includes a definition of prevention descriptions of substance abuse risk and protective factors and a discussion of the key features of three prevention

strategies—universal, selective, and indicated—that have proven effective. The handbook also explains how prevention efforts can be strengthened by using knowledge gained through research.

- *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual* is a 9-hour, modular training curriculum, designed for use by training facilitators in introducing prevention practitioners and community members to the basic theory of substance abuse prevention and the three prevention strategies. The facilitator's manual also provides them with the skills to assess and increase the readiness of a community to launch a prevention effort. The curriculum includes talking points for lectures, instructions for conducting discussions and exercises, and overheads and handouts.

These four components are intended to be used together as a set. Three stand-alone documents provide more intensive guidance on implementing the three prevention models introduced in the core set of materials. Each manual provides more detailed information about the strategy, including a rationale for its use and a description of a research-based program model that illustrates the strategy. Information is provided on key elements of the program, issues that need to be addressed to implement the program successfully, and resources that practitioners can access for more information about the program. These models have been selected because National Institute on Drug Abuse (NIDA) research indicates that these programs have been effective in preventing adolescent drug abuse. The following are the three stand-alone resource manuals:

- *Drug Abuse Prevention for the General Population* discusses the history and key features of universal prevention programs. The Project STAR Program—a communitywide program designed to teach adolescents the skills necessary to counteract the psychosocial influences that increase the likelihood of substance abuse—is described as an illustration of a universal prevention strategy.

- *Drug Abuse Prevention for At-Risk Groups* discusses the history and key features of selective prevention programs. The Strengthening Families Program—a family-focused program targeting children ages 6 to 10 whose parents are substance abusers—is described as an illustration of a selective prevention strategy.

- *Drug Abuse Prevention for At-Risk Individuals* discusses the history and key features of indicated prevention programs. The Reconnecting Youth Program—a school-based program targeting 9th- through 12th-grade students who are at risk for dropping out of school, substance abuse, and suicidal behavior—is described as an illustration of an indicated prevention strategy.

These examples of universal, selective, and indicated prevention illustrate how different communities have implemented these approaches effectively and show how the models can be varied in different settings. Their inclusion in these materials does *not* imply an endorsement by NIDA. More information on these program models can be found in a video prepared by NIDA titled *Coming Together on Prevention*, which is available from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See appendix A.) If prevention practitioners determine that one or more of these case examples might be appropriate for their communities, they can use the relevant resource manual as a supplement to the RDA core package. The stand-alone resource manuals are not included as part of the RDA core package and have to be ordered separately. Figure 1 shows how a practitioner might use the documents in this set of RDA materials. Appendix A provides information on how to order the RDA core package, the stand-alone manuals, the video, and other materials on the three programs.

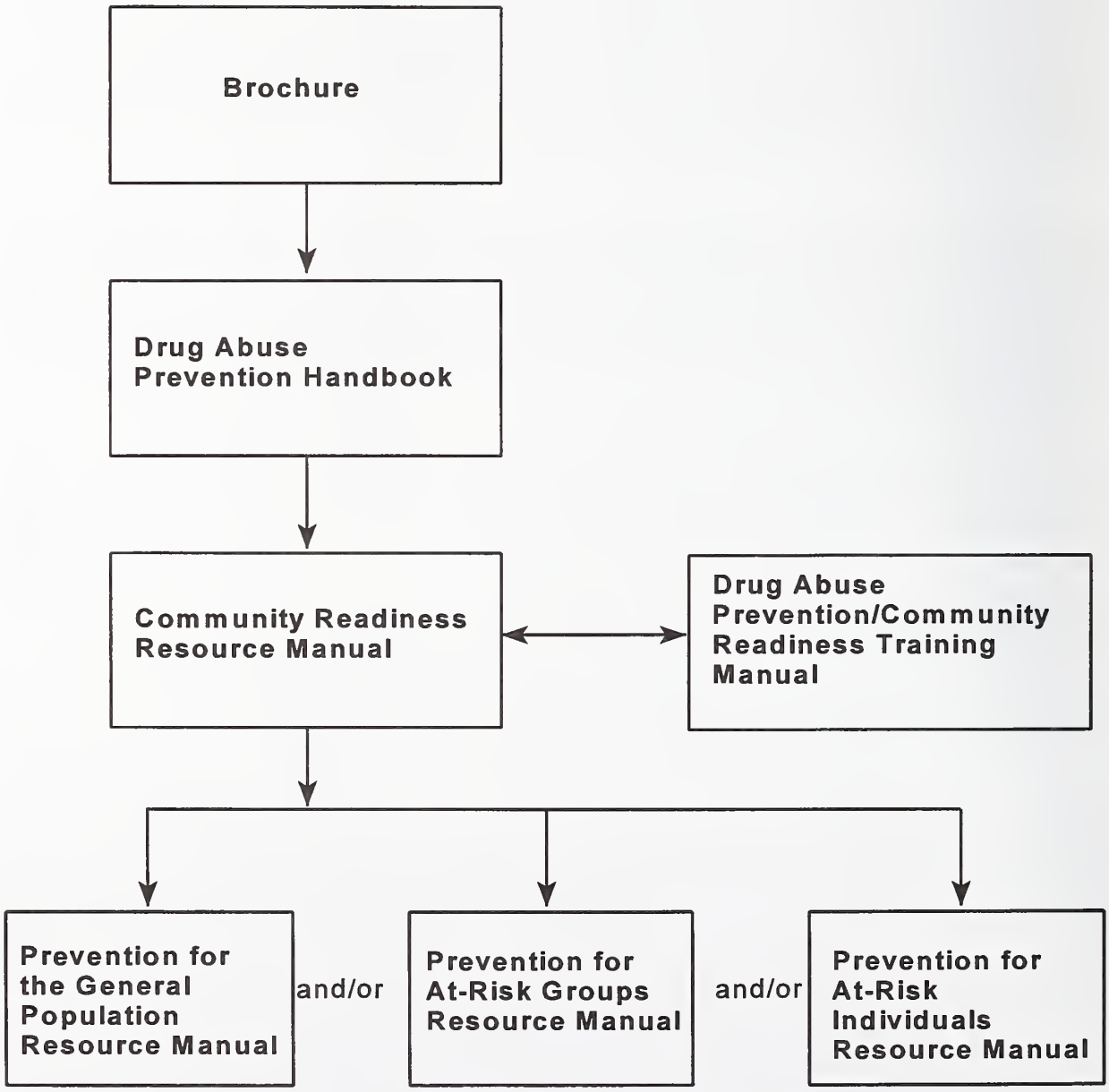
The RDA materials are not intended to be an all-inclusive discourse on drug abuse prevention and programming. The programs presented as illustrations of the three prevention strategies all target children or adolescents. This selection is purposeful because this population has been the major thrust of policy, research, and program efforts. This does not imply that there are no effective substance abuse prevention efforts targeting adults, only that this topic is beyond the scope of these materials.

Throughout this resource manual and the other documents in the drug abuse prevention RDA materials, *substance abuse* is used to refer to illicit drug and alcohol abuse and the use of tobacco products. Readers unfamiliar with the substance abuse and prevention terms used throughout this manual are referred to the Center for Substance Abuse Prevention (CSAP) *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms* referenced in appendix A.

Figure 1

Drug Abuse Prevention

Research Dissemination and Applications Materials



INTRODUCTION

In large metropolitan areas and in rural communities, drug abuse has become a major issue throughout this country. Drug abuse among youth and adults is a serious national health and social problem despite the best efforts of the Federal, State, and local governments. For example, although progress appeared to have been made in decreasing substance abuse among high school seniors in the decade between 1982 and 1992, increased substance abuse among eighth, tenth and twelfth graders in the subsequent 3 years has been confirmed by the Monitoring the Future Survey (NIDA 1996). The findings from this survey suggest possible causes for this upturn in adolescent use, including reduced concern for the negative consequences of substance abuse among youth and significantly decreased levels of substance abuse prevention activity at the local community level.

Substance abuse seriously affects the economic and social stability of communities, contributing to rising health care costs and to the increased costs of alcohol and drug abuse treatment. For example, Rice (1991) estimated that nationally the economic cost of substance abuse in 1988 exceeded $144 billion dollars, with roughly 60 percent of that cost resulting from alcohol abuse. In addition, reduced work productivity and unemployment are heavily correlated with substance abuse. According to the 1985 National Household Survey on Drug Abuse (NIDA 1985), employees who abuse substances have a greater negative impact on the workplace than employees who do not. Drug-related violence and gang activity, poverty, lack of opportunities for youth, and community disorganization are increasing problems in urban communities that are impacted by increased illegal drug trafficking and use and increased drug susceptibility among youth from high-risk environments (Fagan 1987). Youth from low socioeconomic backgrounds are more vulnerable to becoming drug dealers (Elliott et al. 1989), which often leads to substance abuse. Research also has shown considerable overlap between delinquency and school failure and drug abuse among youth in high-risk communities (Huizinga et al. 1991).

Because communities, in many respects, are microcosms of the larger society, the social and economic impacts of substance abuse nationally can be overwhelming on the local community level. However, prevention can play an important role in maintaining community stability. To this end, prevention professionals have begun to take a broader perspective of both the problem and its solution. Rather than viewing substance abuse as a problem whose prevention is the responsibility of a single isolated community segment (e.g., the schools), prevention professionals now emphasize the need to view substance abuse as a problem of the larger community whose members must share collectively in the responsibility for substance abuse prevention. In this view, prevention efforts must reach across and involve multiple and diverse segments of the community (e.g., the schools, the family, religious institutions, grassroots neighborhood organizations, and businesses) and include the segments typically underinvolved, such as business and labor (Join Together 1993). Research has shown that the successful reduction of drug abuse requires the wide-scale involvement of multiple segments of the community (Pentz et al. 1986).

A key reason for including many community segments in prevention programming is that numerous research studies also have shown that developing a consistent communitywide message not to use drugs has proven to be more effective than individual prevention strategies. Single-shot, uncoordinated drug abuse prevention efforts (e.g., short media blitzes, lectures in schools, alternative youth activities, self-esteem enhancement programs) are often ineffective or have limited, short-term benefits (Moskowitz 1989; Goodstadt 1980; 1987).

This communitywide approach to drug abuse prevention allows individual communities to tailor prevention efforts to their local needs and resources. Prevention programs created by local citizens are more likely to succeed and continue operating than programs dictated from outside the community (Heller 1990). Therefore, because local solutions are more likely to have a greater impact in reducing the problem of drug abuse at the local level, it is essential that communities possess the capacity and capabilities that are required to address and prevent drug abuse. Communities must be adequately prepared to initiate substance abuse prevention efforts. Thus, community readiness is vital if a prevention effort is to have a reasonable chance for success at the community level.

Community readiness is more difficult to define than to identify in practice. Essentially, community readiness is the extent to which a community is adequately prepared to implement a prevention effort, that is, the extent to which community leaders are available to take the necessary actions to prevent substance abuse. A community's readiness to undertake prevention programming significantly impacts its success. Regardless of whether communities implement full-scale, comprehensive, communitywide prevention efforts or small-scale neighborhood or organizational efforts, such as by schools or clubs, the support and cooperation of multiple stakeholders is essential for success. Therefore, undertaking a community readiness assessment before implementing any new prevention program makes good sense.

Purpose of This Resource Manual

The purpose of this resource manual is to make the reader aware of the importance of readiness when planning a prevention program and to provide practical tools that communities can use to improve their readiness and implement successful programs. This manual is intended for prevention practitioners and other community members who vary in their training and experience in the area of substance abuse prevention but who are interested in either initiating or expanding their prevention efforts. Thus, the target audience for this document includes prevention program administrators, prevention specialists, community volunteers and community activists, parents, teachers, business and labor leaders, and other individuals and groups who have an interest in substance abuse and its prevention. The primary objectives of this resource manual are to:

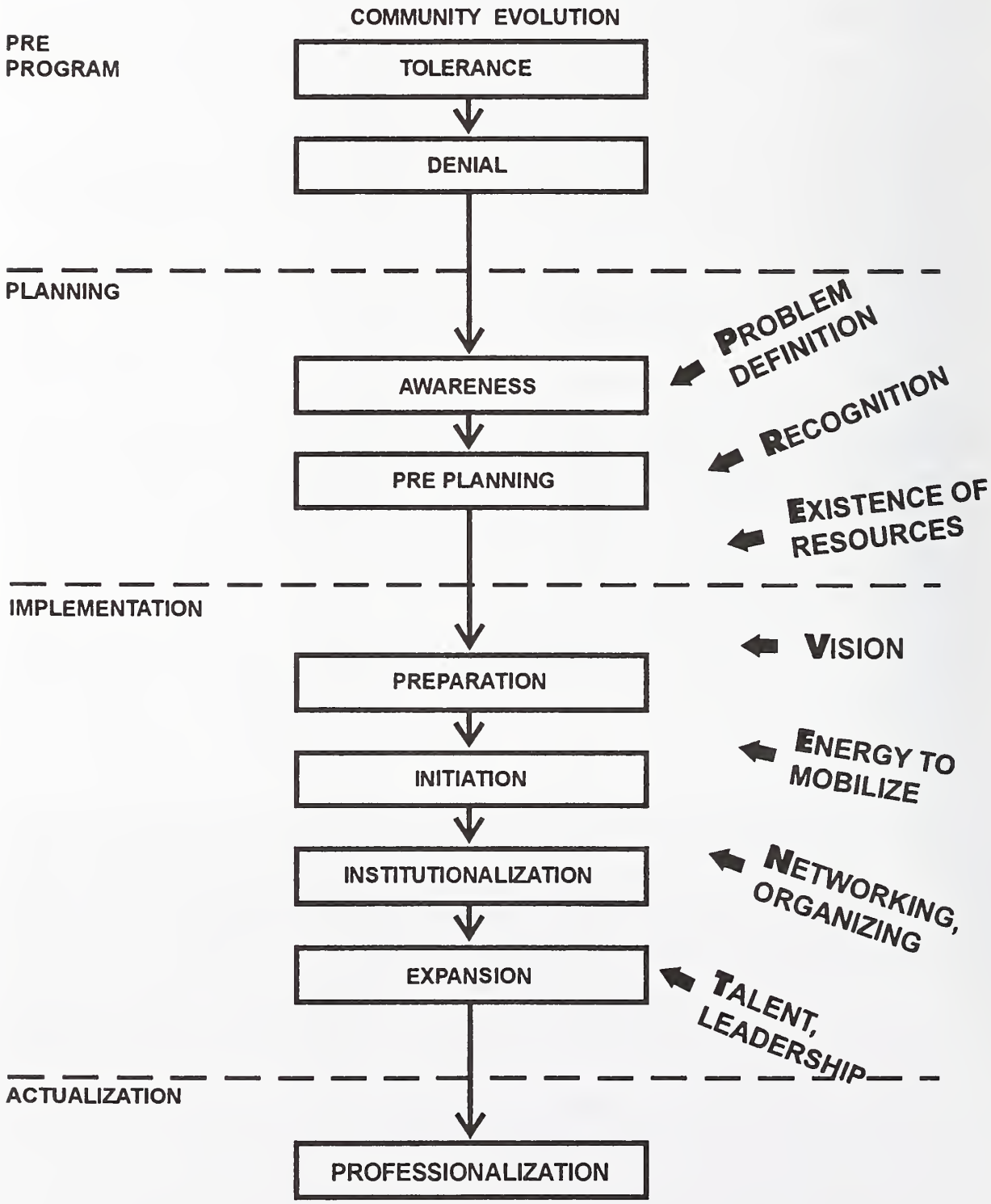
- present the concept of community readiness for substance abuse prevention;

- describe nine stages of community readiness;
- describe seven key factors associated with community readiness;
- provide guidance in the application of procedures to assess community readiness;
- describe seven steps for increasing community readiness;
- provide guidance in the application of the strategies to increase community readiness; and
- motivate the reader to consider community readiness issues in the planning for community prevention efforts.

Figure 2 provides a conceptual framework for the discussion of readiness presented in this manual. It depicts nine stages of readiness through which communities invariably evolve. Communities move sequentially through the nine stages but may fall back to lower stages periodically because of changes in funding, loss of support, talent drain, or disagreements about the mission. Factors associated with program success (shown surrounding the middle stages of readiness and highlighted with the letters P-R-E-V-E-N-T) all should optimally exist for a community to fully achieve what Oetting and colleagues (Oetting et al. 1995) refers to as actualization (i.e., reaching the stage of professionalization at the top of this readiness hierarchy). However, these factors coexist and interrelate with each other and with the nine stages of community readiness—that is, the relationship among factors is not linear nor linked with any specific stage of community readiness. Therefore, to assess a community's readiness, it is important to examine not only its stage of development but also the factors associated with prevention programming success.

The next chapter discusses the nine stages of readiness in more depth, tells how a community's stage of readiness is determined, and suggests strategies for advancing along the readiness continuum. The subsequent chapters discuss indepth seven factors associated with prevention programming success and present strategies for overcoming deficiencies and bolstering community capabilities so that a successful prevention effort can be launched.

Figure 2
Community Readiness for Prevention Programming



COMMUNITY READINESS: WHAT IS IT?

Definition of Community

The term *community* is used here to refer to any group of people who share common interests, problems or needs, and may include neighborhoods, schools, clubs, or groups of people such as children of adult alcoholics. A *sense of community* is the degree of bonding or perceived feelings of attachment to the community of its individual members. One's sense of community is usually strongest at the point closest to one's geographical home or other common social characteristic or affinity (e.g., block or neighborhood, ethnic community, church, school, business). It becomes weaker as the circle is widened. The level of community most effectively targeted for prevention efforts is the one with which people identify most strongly and believe they have the most capacity to influence change.

According to Sarason (1974), some basic ingredients of a sense of community are:

- The perception of the degree of similarity to others within the community;
- An acknowledged interdependence with other members of the community;
- A willingness to maintain this interdependence by giving to or doing for others what one expects from them; and
- The feeling that one is part of a larger dependable and stable community.

No matter how small the community is or how narrowly defined the boundaries are, it is always worthwhile to assess readiness before engaging in full-scale planning and implementation of a prevention program. Although the examples here tend to focus on large-scale efforts that encompass an entire metropolitan area, readiness is equally important for smaller, more targeted efforts, such as selective or indicated programs implemented in individual schools.

Variables Influencing Sense of Community

There are a several variables that influence a person's sense of community, and these variables play a role in how successful a community's efforts will be to increase the sense of belonging among its members. For example, whereas feelings of belonging can be strengthened by staging community events more often and by encouraging members to work together for common goals, some factors that influence individuals' sense of community are difficult to change. These factors include:

- Mobility, length of time in the community and home or business ownership;

- Demographic homogeneity or similarity of community members and similarity of values among community residents;

- Class status and community norms concerning participation, perceptions of interdependence and need to cooperate; and

- Perceived safety of participation and environmental features of community encouraging interaction.

Mobility

A high level of mobility will work against a sense of community. Mobility is most notable in areas with high levels of rental housing. Short-time residents often have little or nothing invested in the community because they are the community residents most likely to move out. Mobility causes difficulty in bonding with longer term residents who may perceive the short-time residents as outsiders. Long-term community residents, usually home or business owners, often feel they have fewer options to move and may choose to stand their ground and fight when conflict arises. For example, participation by long-term community residents in drug abuse prevention efforts may be a product of a desperate determination to defend their turf. Longer term residency increases the probability of a common history among the residents; therefore, these residents may be more motivated to safeguard their community.

Similarity of Community Members

The more similar members of a community are in terms of culture, race or ethnicity, values, and religion, the more likely they will be to work together and create a sense of togetherness. Similarity of interests brings citizens together in a variety of local associations, ranging from religious congregations to hobby clubs and sports teams. Perceived similarity creates a bond of *us*.

Class Status and Community Norms

Class status and community norms related to cooperation and participation in the life of the community also play a role in the sense of community. For example, studies of neighborhood organizations have shown that middle-class females who are homeowners are most ready to participate in community efforts (Prestby et al. 1990). In the past, middle class women had the most time to participate. However, over time, this situation has rapidly changed as more middle income women have joined the workforce. The least affluent, however, should not be written off but should be included as allies and members of the community. Precisely because they have few resources, mobility may not be an option for them. The strains on their time and resources are many, but they may hold a strong attachment to their community and to their neighbors.

Perceived Safety and Environmental Features

In some communities, members may want to reduce drug dealing and abuse to clean up their neighborhood. However, a major barrier to such participation in high-crime areas may be fear resulting from threats, direct or indirect, on the lives of leaders and volunteers. The design of the buildings and location of meetings also can influence participation and community readiness. Meetings well publicized, but held in unsafe and unsecured locations, are not likely to attract many participants.

Effectiveness of Community Prevention Approaches

As discussed below, the effectiveness of community prevention approaches has been empirically demonstrated by research in health promotion, crime and delinquency prevention and community development. Because of these research findings in other prevention fields, community involvement approaches have become popular in the field of substance abuse prevention (Kumpfer and Durant 1991; Kumpfer and Hopkins 1993; Robert Wood Johnson Foundation 1989). Approaches can take many forms—from organized coalitions or partnerships to more limited community-focused strategies. Community coalitions are one strategy that has been used to bring different segments of a community into planning and implementing a prevention effort. Community coalitions or partnerships are groups composed of community-based organizations and individual volunteers who form to bring about large-scale change within their communities. For example, to increase resources and action for drug abuse prevention, community leaders have begun to team with prevention providers to encourage the participation of professionals and local citizen volunteers in community prevention efforts. Research in the areas of health promotion and disease prevention (Florin 1989; Green 1986, 1987; Yin 1977), and drug abuse prevention (Hawkins et al. 1992; Pentz 1986; Pentz et al. 1989) suggests that such coordinated community action is critical to enhancing the effectiveness of these types of community efforts.

Because community coalitions are relatively new in the substance abuse field, there is only limited empirical evidence, beyond anecdotal data, to support their effectiveness in reducing substance abuse (Kumpfer and Hopkins 1993). For example, community psychologists (Florin et al. 1992a; Heller 1990) agree that anecdotal evidence from case studies (Mindick 1986, pp. 250-279; Rich 1986) suggests that some community coalitions are effective. Most research on community substance abuse prevention efforts has been conducted on coalitions that are composed primarily of volunteers from neighborhood block associations (Prestby et al. 1990). However, because of the high dropout rates of these volunteers—as high as 50 percent in some groups (Chavis and Manos 1992)—the research has focused more on factors that contribute to maintenance of coalitions than on factors related to the overall effectiveness of coalitions. Empirical evidence is being gathered about the characteristics of coalition members and coalition operations that contribute to their effective outcomes (Chavis and Wandersman 1990). In

addition, the work of Oetting and colleagues at Colorado State University (Oetting et al. 1995), as well as that of Donnermeyer and colleagues at The Ohio State University (Donnermeyer et al., in press) is beginning to provide some important insights about the factors that contribute to community readiness to mobilize and implement effective community coalition approaches to substance abuse prevention.

One of the earliest communitywide approaches to substance abuse prevention is the Midwestern Prevention Project (Pentz et al. 1989; 1990), which is highlighted in *Drug Abuse Prevention for the General Population*. This prevention project brought together community leaders in business, education, the media, parents' organizations, and service agencies to address the substance abuse problems in two medium-size midwestern communities. The results of this project demonstrated that a community coalition approach to substance abuse is effective in increasing community readiness, enhancing community mobilization, and implementing a broad-scale substance abuse prevention program.

What Is Community Readiness?

Over the past decade, as interest in the need to reduce drug abuse has increased and research has demonstrated the effectiveness of community prevention approaches, researchers and prevention practitioners have discovered that communities vary widely in their interest, ability, and willingness to initiate drug abuse prevention efforts, that is, in their level of readiness (Oetting et al. 1995). Some communities do not recognize that they have a drug abuse problem or deny that such a problem exists. Other communities have not only recognized a drug abuse problem, they have taken positive steps to address it. In these latter communities, there likely is broad popular awareness of the problem; because of a strong sense of community, the citizens believe that correction of the problem is possible. However, still other communities fall somewhere between these two extremes, for example, recognizing that the community has a drug abuse problem but having little knowledge and understanding and perhaps even less capability to address it effectively.

A major challenge for communities wishing to undertake substance abuse prevention efforts is to determine their level or degree of readiness. Readiness of the community can be influenced by and reflected in the degree of readiness of the individual members of the community and in the norms that operate within the community. For example, some community members, especially the identified leaders or gatekeepers, may, for a variety of reasons (not the least of which may be political), be reluctant to identify the existence of a drug abuse problem publicly. Therefore, they may fail to see or choose not to address the problem.

In some circumstances, high levels of drug abuse may not be perceived as a problem because of the existence of certain community barriers such as acceptance of the problem by community leaders and local norms of the community that are supportive of drug abuse. For

example, in some rural communities, alcohol use is a rite of passage and is a part of the social environment of the community. In these communities, establishments where alcohol is served are often centerpieces of community activity, and merchants often will allow alcohol and tobacco sales to minors because of close personal relationships with the parents of the minors. Therefore, a community's readiness to initiate effective substance abuse prevention efforts will vary greatly.

Thus, the degree of readiness within a community can be viewed as a stage in the developmental process in the community in which prevention efforts can be either facilitated or thwarted.

Nine Stages of Community Readiness

Through extensive research on community development and substance abuse prevention efforts, Oetting and colleagues (Oetting et al. 1995) have identified nine stages of readiness through which communities develop: the higher the stage of development, the greater the degree of readiness. The following are descriptions of the nine stages and the characteristics of communities at each stage:

Stage 1: Community Tolerance

Community norms actively tolerate or encourage the behavior, although the behavior may be expected of one group and not another (e.g., by gender, race, social class, or age). The behavior, when occurring in the appropriate social context, is viewed as acceptable or as part of community norm. Those who do not engage in the behavior may be tolerated, but might be viewed as somewhat deviant.

Stage 2: Denial

There is usually recognition that the behavior is or can be a problem. Community norms usually would not approve of the behavior, but there is little or no recognition that this might be a local problem. If there is some idea that it is a problem, there is a feeling that nothing needs to be done about this locally, or that nothing can be done about it.

Stage 3: Vague Awareness

There is a general belief that there is a local problem and that something ought to be done about it. Knowledge about local problems tends to be stereotypical and vague, or linked only to a specific incident or two. There is no immediate motivation to do anything. No identifiable leadership exists, or leadership lacks energy or motivation.

Stage 4: Preplanning

There is clear recognition that there is a local problem and that something should be done about it. There is general information about local problems, but ideas about etiology or risk factors tend to be stereotyped. There are identifiable leaders, and there may be a committee, but no real planning.

Stage 5: Preparation

Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention programs, but it may not be based on formally collected data. Leadership is active and energetic. The program may have started on a trial basis. Funding is being actively sought or has been committed.

Stage 6: Initiation

Enough information is available to justify a prevention program, but knowledge of risk factors is likely to be stereotyped. A program has been started and is running, but it is still on trial. Staff are in training or just finished with training. There may be great enthusiasm because limitations and problems have not yet been experienced.

Stage 7: Institutionalization

One or two programs are running, supported by administration, and accepted as a routine and valuable activity. Staff are trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is not much sense that the limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is not necessarily permanent funding, but there is established funding that allows the program the opportunity to implement its action plan.

Stage 8: Confirmation/Expansion

Standard programs are viewed as valuable and authorities support expanding or improving programs. New programs are being planned or tried out in order to reach more people, those thought to be more at risk or different demographic groups. Funds for new programs are being sought or committed. Data are obtained regularly on extent of local problems and efforts are made to assess risk factors and causes of the problem.

Stage 9: Professionalization

Detailed and sophisticated knowledge of prevalence, risk factors and etiology exists. Some programs may be aimed at general populations, while others are targeted at specific risk factors and/or at-risk groups. Highly trained staff are running programs, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs.

Oetting and colleagues (Oetting et al. 1995) have found that as communities achieve successively higher stages, they realize greater improvement in their degree of readiness. Therefore, to increase a community's readiness for prevention programming and thereby improve the likelihood that a prevention effort will succeed, it is important to give careful consideration to these nine stages of community readiness development during the process of conducting an objective assessment of community readiness. Oetting's group's process for assessing stages of readiness, as well as strategies for stage advancement, is discussed more fully at the end of this chapter.

Why Increase Community Readiness?

There are several reasons to increase community readiness. These are presented below under the two key factors of increased program effectiveness and continuity.

Effectiveness

The primary reason for increasing community readiness for substance abuse prevention is effectiveness. Enduring, coordinated, and comprehensive prevention efforts at the local level are more likely to have the desired impact, particularly if substance abuse professionals work with local citizens and community leaders from many segments of the community in planning, coordinating, and implementing the prevention effort (Kumpfer 1989, pp. 194-221; Kumpfer and Durrant 1991). Increasing community readiness for substance abuse prevention by involving many different individuals and organizations from many segments within the community that shape community values, attitudes, and norms can improve a community's understanding of the causes and consequences of drug abuse as well as improve the success of prevention programs.

For example, major changes in community and national norms concerning tobacco use have contributed significantly to the effectiveness of prevention programs in reducing tobacco use in this country. Hansen and Graham (1991) believe prevention programs that are successful in changing community norms will be the most effective in reducing drug abuse. Changing community norms require that all segments of the community be involved in substance abuse

prevention programs. Howard-Pitney (1990) notes that "There is a growing recognition and belief that major shifts in unhealthy lifestyles and community norms can be accomplished through citizen participation and community development" (pp. 9-10).

An assessment of readiness also can help a community determine the likelihood of a program's effectiveness even though the program is undertaken in a community showing minimal or only marginal readiness or when community readiness is so great that almost any activity will be effective. Often assessments of readiness will help determine how scarce resources can be allocated. The challenge is to distinguish marginal communities from those with many readiness factors already in place, for example, those in which modest amounts of new resources can make a difference in prevention efforts. Communities in social and economic crisis will rarely respond to drug abuse prevention initiatives alone without major supportive efforts to address underlying or associated social and economic problems.

Continuity

A second reason for increasing community readiness is that prevention programs are more likely to succeed and continue to operate when they are created by local citizens and tailored to the needs and resources of the local community. Heller (1990) has called for a *return to community* and increased community empowerment to counteract the observations that "local communities have diminished power and political influence, with decisions and resources flowing downward from the federal level" (p. 12). Prevention programs that are designed by prevention professionals who come from outside of the community and that do not include local input and cultural modifications often do not address the primary reasons why local youth and adults use alcohol and other drugs. Therefore, local substance abuse prevention coalitions are needed to provide the necessary community readiness and community input to increase the effectiveness of prevention efforts.

Increasing community readiness also can serve to provide a basis on which appropriate funding decisions can be made. For example, when universities or community agencies attract Federal, State, or county funding or funding from foundations for prevention programs, they must be sure that the community in which the program will be implemented is receptive and ready for the new program. A careful assessment of community readiness can provide a basis for which decisions can be made for effectively directing funds to one segment of the community or another, and for directing funds most effectively within a particular segment of the community. For example, although a community may not be adequately prepared to implement a prevention program in all of its public housing neighborhoods because it does not have the necessary funding to do so, a community readiness assessment may indicate the one or two neighborhoods where there is community consensus that the prevention program is needed most. Thereby the

community can gain important insights for directing scarce resources to areas of the community with the greatest needs, the greatest likelihood for impact, and the highest probability for successful outcomes.

Assessing a Community's Stage of Readiness

Oetting and colleagues (Oetting et al. 1995) have collected data throughout the United States from 46 predominantly white communities with populations of 10,000 or fewer, in addition to 60 communities in which ethnic minorities constituted at least 30 percent of the population. They found that most communities fall into one of two stages of readiness:
(1) vague awareness or (2) institutionalization. The process Oetting's group used to assess readiness is discussed below, followed by suggestions on how to strengthen readiness.

The process of assessing the stage of readiness, which Oetting's group has validated, takes three steps (Donnermeyer et al., in press):

- Staff identify key informants, depending on the size of the community and constraints.

- A skilled, knowledgeable interviewer holds semistructured interviews with the key informants.

- The interviewer meets with a team of colleagues to rank responses and determine the stage of readiness.

These steps are designed to help a community assess its readiness quickly with minimal effort. It is suitable where resources do not exist for conducting comprehensive surveys or undertaking other large-scale assessments.

Selecting Key Informants

Individuals from the community presumed to be knowledgeable about prevention or to have an interest or stake in prevention efforts are selected, preferably including: a school counselor or person responsible for alcohol and other drug education or counseling; a community authority, such as the mayor; a local media representative such as the editor of a local newspaper; and a community leader in the area of drug abuse prevention.

Interviewing Key Informants

Exhibit 1 contains the questionnaire used to interview key informants. Generally, it is recommended that the interviewer be someone who is knowledgeable about prevention strategies and terminology. Interviews are conducted by telephone. Although the interviews take only about 30 minutes to complete, the researchers have found that it takes several weeks from the point of the initial contact to completion of the interviews to allow for callbacks and scheduling.

Ranking Responses

Readiness is assessed on six dimensions:

- prevention programming;
- knowledge about prevention programming;
- leadership;
- knowledge about the problem;
- funding for prevention; and
- community climate.

There are six sets of readiness descriptive statements—one set for each of the six dimensions—and each set contains nine anchor statements linked to the nine stages of readiness. For each dimension, the team finds the anchor statement that most closely describes the responses of the key informants to dimension-specific questions in the Key Informants Interview Questionnaire. The researchers have found much consistency in responses among key informants and among the six dimensions. The anchor statements were determined through a validation process that involved the development and ranking of statements by a group of experts. Exhibit 2 presents the readiness descriptive statements for one of the six dimensions—Prevention Programming. The reader is referred to appendix A for further information on obtaining the descriptive statements from the researchers.

Another community readiness assessment approach has been developed by Goodman and Wandersman at the University of South Carolina (Wandersman et al. 1991; 1996). This approach utilizes a community key leader survey, as shown in exhibit 3. The key leader survey measures three areas—awareness, concern, and action across multiple community levels. Key leaders respond to questions in these three areas both on a personal level and a perceptual level of their organization's responses. The reader is referred to appendix A for further information on contacting the researchers.

Strategies for Improving Readiness

Based on Oetting's approach, exhibit 4 lists strategies communities can take to strengthen their prevention programming, depending on their stages of readiness. In general, communities at the lower stages of readiness need to focus on building awareness. For communities at the very bottom—in which drug abuse is tolerated—much activity will occur behind the scenes through one-on-one and small-group meetings intended to make people aware of the harmful effects of drug abuse in general. As the community develops, the type of awareness-building activity shifts to building awareness of specific consequences in the community and letting people know about programs and resources available to address the problem. Publicity campaigns involving broad information dissemination are most appropriate only after the community has moved beyond denial.

Communities in the preparation and initiation stages benefit most from systematic and complete information about the local drug problem and from planning activities. Staff training usually is needed during the initiation stage. Communities at the institutionalization stage need to focus on self-evaluation and revision; training continues to be important. Continued networking with other leaders and community organizations and continued training also are important at the higher stages.

Exhibit 1

Key Informants Interview Questionnaire

Readiness Dimensions

1. PREVENTION PROGRAMMING
2. KNOWLEDGE ABOUT PREVENTION PROGRAMS
3. LEADERSHIP
4. KNOWLEDGE ABOUT THE PROBLEM
5. FUNDING FOR PREVENTION
6. COMMUNITY CLIMATE

Questions (Numbers in parentheses indicate the program dimension(s) above to which each question relates.)

1. What types of drug prevention programs or activities have occurred in your community? (1&2)
    a. How long have these programs been in your community? (1&2)
    b. Who is served by these programs? (1&2)
    c. Is there a need to expand these services? If no, why not? (1&2)
    d. Are there plans to expand? If yes, what are the plans? (1&2)
    e. How are these programs viewed by the community? (2&6)
2. What is the general attitude about substance abuse in your community? (3,4&6)
    a. Does the community see substance abuse as a problem? (3,4&6)
    b. Would or does the community support a prevention plan? If yes, how? (3&6)
    c. Are the leaders in your community involved in prevention efforts (list)? (3)

Exhibit 1
(Continued)

d. What community organizations have a focus on prevention? (3)

3. Is there information available on local substance abuse prevalence? If yes, from whom? (4)

4. How is that information disseminated? And to whom? (4)

5. Who provides funding for these programs and how long will it continue? (5)

6. What is the community's attitude/belief about funding prevention programs? (5&6)

7. Is your community aware of the costs of running a prevention program? (4&5)

8. Are you aware of any proposals that have been written that address the issue of prevention? (5)

   Are any funded or waiting? (5)

9. Is the lack of community involvement a major obstacle in your prevention efforts? (6)

10. Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)

11. What are the primary obstacles to prevention efforts in your community? (6)

12. What is the next step your community needs to take in the area of prevention? (general—all 6 dimensions)

Exhibit 2

READINESS DESCRIPTIVE STATEMENTS

1. PREVENTION PROGRAMMING

Level 1. No plans for prevention are likely in the near future.

Level 2. No plans for prevention are likely in the near future.

Level 3. There aren't any immediate plans, but will probably do something sometime.

Level 4. There have been community meetings or staff meetings, but no final decisions have been made about what we might do.

Level 5. One or more programs are being planned and staff are being selected and trained for them.

Level 6. One or more prevention programs are being tried out now.

Level 7. One or more programs have been running for several years and are fully expected to run indefinitely, no specific planning for anything else.

Level 8. Several different programs in both the community and schools are running, covering different age groups and reaching a wide range of people.

Level 9. Evaluation plans are routinely used to test effectiveness of many different programs and the results are being used to change and improve program constantly.

Exhibit 3

Community Key Leader Survey

Directions: For the following questions, circle the number of the response that best fits YOUR PERSONAL OPINION.

	Not at all True	Slightly True	Moderately True	Very True
1. I am aware of programs in my community which address alcohol and other drug abuse prevention.	1	2	3	4
2. I spend time collaborating with others concerning the prevention of alcohol and other drug abuse in my community	1	2	3	4
3. I don't know why preventing alcohol and other drug use is so important for communities to address.	1	2	3	4
4. I am interested in learning more about community-related alcohol and other drug abuse prevention programs.	1	2	3	4
5. I believe preventing alcohol and other drug abuse among youth is important.	1	2	3	4
6. I am not certain why some individuals consider alcohol and other drug abuse prevention important.	1	2	3	4
7. I am not interested in becoming actively involved in improving alcohol and other drug abuse prevention programs in my community	1	2	3	4
8. I don't know what programs in my community address alcohol and other drug abuse.	1	2	3	4
9. I am interested in more information on the time and energy commitments that a community-related alcohol and other drug abuse prevention program would require.	1	2	3	4
10. I know which alcohol and other drug abuse prevention programs serve my community.	1	2	3	4
11. I can distinguish the type of services offered by the different alcohol and other drug abuse programs in my community.	1	2	3	4
12. I am concerned about whether my community has sufficient alcohol and other drug abuse prevention programs.	1	2	3	4
13. I am not involved with the alcohol and other drug abuse community prevention programs in my community.	1	2	3	4

Exhibit 3
(Continued)

Directions: For the following questions, circle the number of the response that best fits your answer.

	Decreased a Lot	Decreased a Little	Not Changed	Increased a Little	Increased a Lot
14. In the last 12 months, my personal concern for preventing alcohol and other drug abuse in my community has:	1	2	3	4	5
15. In the last 12 months, my personal knowledge of the risk factors that contribute to alcohol and other drug abuse has:	1	2	3	4	5
16. In the last 12 months, my personal knowledge of community programs that address alcohol and other drug abuse has:	1	2	3	4	5
17. In the past 12 months, my personal involvement in organized activities for the prevention of alcohol and other drug abuse has:	1	2	3	4	5

Exhibit 3
(Continued)

Directions: For the following questions, circle the number of the response that DESCRIBES YOUR ORGANIZATION.

	Not at all True	Slightly True	Moderately True	Very True	Don't know enough to judge
18. My organization is involved with alcohol and other drug abuse prevention programs in our community.	1	2	3	4	5
19. Members of my organization are currently learning what alcohol and other drug abuse community prevention programs exist in our community.	1	2	3	4	5
20. My organization has a written policy concerning the use of alcohol or other drugs by employees.	1	2	3	4	5
21. In general, staff in my organization know which alcohol and other drug abuse programs serve our community.	1	2	3	4	5
22. As part of its mission, my organization is concerned with preventing alcohol and other drug abuse among youth.	1	2	3	4	5
23. Members of my organization are assigned to collaborate with others concerning the prevention of alcohol and other drug abuse in our community.	1	2	3	4	5
24. My organization is interested in information on the time and energy commitments that a community related alcohol and other drug abuse prevention program would require.	1	2	3	4	5
25. In general, staff in my organization can distinguish the types of services offered by different alcohol and other drug prevention programs in our community.	1	2	3	4	5
26. In general, staff in my organization are aware of community programs that address alcohol and other drug abuse prevention.	1	2	3	4	5

Exhibit 3
(Continued)

Directions: For the following questions, circle the number of the response that best fits your answer.

	Decreased a Lot	Decreased a Little	Not Changed	Increased a Little	Increased a Lot	Don't know enough to judge
27. In the past 12 months, our organization's involvement in our community for addressing alcohol and other drug abuse has:	1	2	3	4	5	6
28: In the last 12 months, our organization's exchange of information with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
29. In the last 12 months, our organization's referrals to or from other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
30. In the last 12 months, our organization's sharing of resources (e.g. equipment, supplies) with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
31. In the last 12 months, our organization's co-sponsoring events with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
32. In the last 12 months, our organization's coordinating services with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
33. In the last 12 months, our organization's undertaking joint projects with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
34. In the last 12 months, our organization's participation in media coverage concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6

Exhibit 3
(Continued)

Directions: For the following questions, circle the number of the response that best fits YOUR PERSONAL OPINION.

	Not at all True	Slightly True	Moderately True	Very True
35. I am aware of specific programs offered to employees and their families in the workplace which address alcohol and other drug abuse prevention.	1	2	3	4
36. I am aware of specific programs offered to employees and their families in the workplace which address child and spouse abuse prevention.	1	2	3	4
37. It is very effective to offer alcohol and other drug abuse prevention resources to employees and their families at their Workplace.	1	2	3	4
38. It is very effective to offer child and spouse abuse prevention resources to employees and their families at their Workplace.	1	2	3	4
39. My organization would be quite willing to make available alcohol and other drug abuse prevention resources to employees and their families.	1	2	3	4
40. My organization would be quite willing to make available child and spouse abuse prevention resources to employees and their families.	1	2	3	4
41. I am aware of the POWER Workplace program.	1	2	3	4

Exhibit 3
(Continued)

Directions: Please take a moment to circle the answer to the following questions about yourself.

42. GENDER - Which one describes your sex?

1. Male
2. Female

43. AGE - Which of the following categories include your age?

1. Under 20 years old
2. 20 to 29 years old
3. 30 to 39 years old
4. 40 to 49 years old
5. 50 to 59 years old
6. 60 to 69 years old
7. Over 70 years old

44. RACE - Which of the following describes your race?

1. African-American (Black)
2. American Indian
3. Asian
4. Caucasian (White)
5. Hispanic
6. Other (please specify)_____

45. EDUCATION - What is the highest level of education that you completed?

1. Eighth grade or less
2. Some high school
3. High school graduate
4. Vocational school beyond high school
5. Some college
6. College graduate education
7. Some graduate education
8. Graduate degree

46. OCCUPATION - Which of the following categories describes your occupation? (Circle the best one choice)

1. Executive, Director or Services Manager
2. Professional
3. Technical
4. Sales
5. Administrative support (e.g., clerical, secretarial)
6. Service
7. Industrial
8. Homemaker
9. Unemployed
10. Other (please specify)_____

47. TYPE OF ORGANIZATION - Which of the following categories describes your organization? (Circle the best one choice)

1. Private Business (for profit)
2. Government Agency
3. Non-Profit Private Social Agency
4. Religious Organization
5. School
6. Other (please specify)_____

48. LENGTH OF TIME IN CURRENT POSITION - Which of the following categories describes the length of time you've been in your current position? (Circle the best one choice)

1. Less than 1 year
2. 1 - 2 years
3. 3 - 5 years
4. 5 - 10 years
5. More than 10 years

Thank you for your time and effort. Please place survey in return envelope. No postage is necessary. All responses are treated with confidentiality.

Exhibit 4

Appropriate Strategies for Each Stage of Readiness

STAGE	STRATEGIES
1. Community Tolerance	a. Small-group and one-on-one discussions with community leaders to identify perceived benefits of substance abuse and how norms reinforce use. b. Small-group and one-on-one discussions on the health, psychological, and social costs of substance abuse with community leaders to change perceptions with those most likely to be part of the initiation set that begins development of programs.
2. Denial	a. Educational outreach programs on the health, psychological, and social costs of substance abuse to community leaders and community groups interested in sponsoring local programs. b. Use of local incidents that illustrate harmful consequences of substance abuse in one-on-one discussions and educational outreach programs.
3. Vague Awareness	a. Educational outreach programs on national and State prevalence rates of substance abuse and prevalence rates in other communities with similar characteristics to community leaders and possible sponsorship groups. Programs should include use of local incidents that illustrate harmful consequences of substance abuse. b. Local media campaigns that emphasize consequences of substance abuse.

Exhibit 4
(Continued)

STAGE	STRATEGIES
4. Preplanning	a. Educational outreach program that include prevalence rates and correlates or causes of substance abuse to community leaders and sponsorship groups. b. Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles. c. Local media campaigns emphasizing the consequences of substance abuse and ways of reducing demand for illicit substances through prevention programming.
5. Preparation	a. Educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented. b. Educational outreach programs for community leaders and local sponsorship groups on prevention program, goals, staff requirements, and other startup aspects of programming. c. A local media campaign describing the benefits of prevention programs for reducing consequences of substance abuse.
6. Initiation	a. Inservice educational training for program staff (paid and/or volunteer) on substance abuse consequences, correlates, and causes and the nature of the problem in the local community. b. Publicity efforts associated with the kickoff of the program. c. A special meeting to provide an update and review of initial program activities with community leaders and local sponsorship groups.

Exhibit 4
(Continued)

STAGE	STRATEGIES
7. Institutionalization	a. Inservice educational programs on the evaluation process, new trends in substance abuse, and new initiatives in prevention programming. Either trainers are brought in from the outside or staff sent to programs sponsored by professional societies. b. Periodic review meetings and/or special recognition events for local supporters of prevention program. c. Local publicity efforts associated with review meetings and recognition events.
8. Confirmation/Expansion	a. Inservice educational programs on conducting localized epidemiologies to target specific groups in the community for prevention programming. Either trainers are brought in from the outside or staff are sent to programs sponsored by professional societies. b. Periodic review meetings and/or special recognition events for local supporters of prevention programs. c. Results of research and evaluation activities of the prevention program are presented to the public through local media and/or public meetings.
9. Professionalization	a. Continued inservice training of staff. b. Continued assessment of new drug-related problems and reassessment of targeted groups within community. c. Continued evaluation of program effort. d. Continued update on program activities and results for the benefit of community leaders and local sponsorship groups and periodic stories through local media and/or public meetings.

The preceding discussion on the nine stages of readiness through which communities evolve tends to focus on the psychological concepts (e.g., awareness of, need, willingness to explore options, commitment to action) of a community's readiness to implement prevention programming. Hence, the assessment and strategy components of the discussion address ways to determine a community's readiness stage along this continuum to undertake prevention efforts and make suggestions for advancing along the evolutionary path.

Another way to look at community readiness is derived from research discussed previously on health promotion, crime and delinquency prevention, and community development. Looking at this information allows a focus on the organizational or systems aspects of community readiness. This perspective identifies seven factors associated with successful prevention efforts (the PREVENT acronym in figure 2):

- **P**roblem Definition
- **R**ecognition of Problem by Community
- **E**xistence of and Access to Resources
- **V**ision and Plan
- **E**nergy to Mobilize and Sustain Prevention Activities
- **N**etworking With and Support of Stakeholders
- **T**alent; Leadership Structure; Sense of Community

As shown in figure 2 on page 8, these factors overlap with the nine stages of community development. This paradigm represents an attempt to explain this interface; it is not based on empirical research. The remainder of this resource manual looks at community readiness from this perspective. The following two chapters discuss at length these seven factors and how to assess them. If any are deemed to be deficient, specific steps are then presented on how to enhance them. Again, the reader should not presume linearity in the order in which the factors or steps are discussed. The PREVENT acronym has been developed solely to help readers remember the seven factors associated with prevention programming success.

ASSESSING COMMUNITY READINESS

Seven factors consistently have been found to be associated with the successful implementation and maintenance of substance abuse prevention efforts. These factors are believed to be key in determining a community's readiness for prevention programming and its ability to progress smoothly through the developmental stages to professionalism. This chapter identifies and describes these factors and discusses how to assess each of them. The next chapter on increasing community readiness provides guidance on specific steps that can be taken to strengthen factors deemed deficient on assessment.

The seven factors associated with community readiness are:

- Key Factor 1: **P**roblem Definition
- Key Factor 2: **R**ecognition of Problem by Community
- Key Factor 3: **E**xistence of and Access to Resources
- Key Factor 4: **V**ision and Plan
- Key Factor 5: **E**nergy to Mobilize and Sustain Prevention Activities
- Key Factor 6: **N**etworking With and Support of Stakeholders
- Key Factor 7: **T**alent; Leadership Structure; Sense of Community

The listing of each of these key factors is not intended to imply that they actually occur in any particular order, either chronological or otherwise. However, as listed above, the first letter of the beginning of each of the seven key factors spells the acronym PREVENT, providing an easy way to remember the seven key readiness factors. The factors can be reordered as necessary for any particular community.

It is also important to understand that although community readiness is a developmental process, these seven readiness factors are not merely present or absent. Each may run the gamut from minimally present to optimally present, and the readiness status can change over time. Therefore, community readiness is not a static process; it is a dynamic process. Consequently, readiness assessment also is not a static process, but is ongoing.

If all the factors of community readiness are assessed before a prevention program is planned and implemented and if all are strong, then the program will have a greater likelihood of being implemented as planned and of being successful in affecting the target population. Each factor is discussed below, and the discussion is followed by a list of possible questions that can be used to assess the readiness of a community on that particular factor.

Key Factor 1: Problem Definition

In assessing community readiness to implement any kind of substance abuse prevention program, it is necessary to determine whether there is enough evidence that a substance abuse problem exists in the community. This information is needed by program funders and to guide the choice of the most appropriate type of research-based prevention program.

Beyond identifying the type of drug problem (e.g., cocaine, alcohol, marijuana), it is critical in prevention planning to determine the extent of the problem (i.e., incidence and prevalence), who has the problem, where in the community the problem exists, and the risk and protective factors that could be changed by the prevention effort. Identifying the factors that place people at greater risk or reduce their susceptibility to substance abuse within their local community context determines the types of prevention efforts that would best address the identified need.

Risk factors are those circumstances and processes that place an individual at risk for developing substance abuse problems, whereas protective factors are those circumstances and processes that protect an individual from developing drug abuse problems. For the risk and protective factors associated with substance abuse, research has shown that certain individual and community influences, along with early drug use, are the most significant predictors of substance abuse. Examples of individual and community influences that contribute to drug abuse include negative social behavior or aggressive behavior, early onset of substance abuse, lack of participation in social activities, social norms of drug acceptance, and exposure to situations and environments where drugs are readily available. Examples of individual or community influences that protect against drug abuse can be the converse of the risk factors, such as strong family values that support abstinence from substance abuse, positive social behavior or behavior consistent with positive social activities, early rejection of drug abuse, active participation in prosocial activities such as Boys and Girls Clubs, school environment and norms that reject substance abuse, and exposure to situations and environments where drugs are not readily available or accessible. Therefore, in assessing the definition of the drug abuse problem within a community, it is important to include identifying the possible risk and protective influences at play among the members of the populations to whom prevention efforts will be targeted. For a more detailed discussion of risk and protective factors, the reader is referred to the handbook *Drug Abuse Prevention: What Works*.

Existing social and/or health data, often called indicators, will help the assessment. If information from previous surveys or other kinds of data are not sufficient for clear identification of the substance abuse problem, it may be necessary to conduct a formal needs assessment.

Readiness Assessment Questions

The following are examples of questions that might be included in a community's assessment of its substance abuse problem:

- What risk factors are present?
  - Transient population
  - Norms supporting drug abuse
  - Drug dealing/crime
  - Absence of alternatives
  - Disorganization
- What types of drugs are abused?
- By whom?
- Where in the community does drug-abusing behavior occur?
- What data are available about the nature and extent of the local drug problem?
- What new data can be collected?
- By whom?
- Who will fund the data collection?
- Is drug abuse tolerated in some areas?
- What protective factors are present?
- What prevention activities already exist? What are the gaps in services?
- What areas (or groups) of the community are most affected by substance abuse?
- Has any previous needs assessment been conducted that could provide information?
- Where could the community intervene most effectively to address the problem?

Several different methods can be used, including telephone or face-to-face interviews with key leaders, youth, parents, business leaders, teachers, and others within the community. Surveys conducted by mail also can be used.

An important consideration for a needs assessment is whether the local community has the expertise to conduct a needs assessment. This is a major readiness consideration because an assessment conducted by an outside expert can be expensive. However, if funding is limited for the needs assessment, costs can be reduced by training local volunteers or students to collect the needed data. Involving community members in the needs assessment can increase local commitment and involvement. The strategy of using community volunteers to collect needs

assessment data has proven to be successful for the Centers for Disease Control health promotion program (Kreuter 1992). A more detailed discussion of community needs assessment will be presented in the next chapter on improving community readiness.

Key Factor 2: Recognition of Problem by Community

Implementing a new drug abuse prevention program requires community support. Support will increase if the community members and prevention specialists alike recognize the problem and participate in the implementation of appropriate prevention strategies to address them. Communities in which there is broad popular awareness of the problem have a greater chance of prevention programming success than those in which there is only limited, specialized, or no awareness of the problem.

Readiness Assessment Questions

To determine whether community recognition of a substance abuse problem exists, the following are examples of the types of questions that can be addressed:

- To what extent does the community believe there is a drug problem?
- What are the perceptions of the drug problem? How accurate are they?
- Has there been an event or incident that has aroused concern?
- How do key leaders perceive the drug problem?
- How are drugs portrayed by local media?
- Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?
- How often do stories disclose the consequences of drug-abuse-related problem behaviors?
- What types of drug abuse problems are currently reported?
- What are perceptions of the causes of/possible solutions to the problem?

A community can assess the degree of recognition of a drug problem through a variety of methods, including conducting community attitude surveys, conducting focus group discussions with citizens, conducting surveys of key community leaders, listening to remarks at public meetings, and analyzing stories in the local media, including newspapers, radio, and television. Information about possible resources that can be used for conducting community attitude and key leaders' surveys can be found in appendix A.

A survey of local newspapers, magazines, newsletters, and other similar publications can provide a rough gauge of public concern. Newspaper archives at the local public library are a valuable resource for communities that want to assess media coverage of substance abuse issues. There are a many issues that a community can consider in surveying the media, such as how frequently newspaper headlines and photo captions refer explicitly to the substance abuse problem, whether articles and editorials clearly indicate when drug or alcohol abuse is associated with a

news item, and whether a particular event has aroused general public concern. Newspaper stories and other media coverage also provide a good gauge of community attitudes. The tone of a story—whether positive or negative—how a story involving drugs is portrayed, and other factors can provide a sense of how the community views drug abuse.

Key Factor 3: Existence of and Access to Resources

Beginning a prevention program requires access to at least a minimum of resources. Therefore, an important consideration in determining the readiness of a community to be involved in and maintain effective prevention programs is whether there currently exists, or will continue to exist, sufficient community resources. In this context, resources are broadly defined to include staff (both professional and volunteer), money, space and program materials.

Professional Staff Resources

In addition to needing monetary resources, prevention programs need knowledgeable professionals who have training in substance abuse prevention or at least a background in the delivery of social services to the target population. An assessment can be conducted of existing professional support that can be recruited for the prevention program, including paid staff, volunteers, consultants, or staff reassigned from community agencies or businesses to participate on advisory or working groups. A community also can consider support that could be found through local colleges and universities and private consulting firms and can assess the availability and capabilities of these professionals to assume responsibility for working on a community prevention effort.

Volunteer Resources

The overall level of community readiness will greatly influence the willingness of community volunteers, both professionals and grassroots citizens, to participate in the planned prevention effort. Therefore, the community can determine the likelihood of attracting the level of volunteer support needed to maintain the prevention effort and determine what must be done to increase the benefits and decrease the costs of volunteer participation in the effort.

Funding Resources

Existing funding within community agencies can be reallocated or new funding can be attracted from outside the community to support the prevention effort. The community can identify a grantwriter or funding development specialist to help with the effort to attract the necessary funding. Some community members may have the skills and capabilities to develop successful funding proposals and be willing to write proposals for little or no cost.

Facilities and Equipment

A major factor in community readiness for implementing any type of prevention effort is availability and adequacy of needed facilities and equipment. Although staffing deficiencies often can be overcome with funding from local, State, or Federal sources, it is difficult to locate funding for space, furniture, or equipment. Some prevention efforts have been substantially hindered because of the inadequacy of the facilities and materials needed to run the program. The

Readiness Assessment Questions

To determine whether adequate resources exist and are accessible, the following are examples of the types of questions that the community can address in an assessment:

- What human resources are available to staff a prevention project?
  - Professional?
  - Volunteer?
  - Other?
- How much time can they commit?
- What facilities and equipment are available to support the effort?
- What potential funding exists for the effort?
  - Federal or State grants?
  - Private foundations or corporations?
  - Agencies (out of existing budgets)?
- What *pro bono* help is available?
- — Legal?
  - Accounting?
  - Advertising?
  - Research design/evaluation?
- What in-kind services are available?
  - Word processing
  - Duplication
  - Mail
  - Telephones
  - Computer time
  - Other
- Can funds be redirected from or combined with those of other programs to address the drug problem?
- Are prevention services providers, as well as community volunteers, willing to commit additional time to the program effort if funds are limited?

availability, accessibility, and security for program participants, as well as staff, are major issues to be carefully considered when assessing the adequacy of proposed facilities.

Key Factor 4: Vision and Plan

A community readiness assessment must determine whether or not the community has an idea or dream whose pursuit will provide a mission and rallying point for the prevention activity. A shared community vision of substance abuse prevention will provide the necessary direction for strategic planning actions and enhance the effectiveness of the prevention program. Therefore, community readiness will require that the community establish and engage in a strategic planning process that will produce a plan of action for implementing the prevention effort. The plan, at a minimum, can identify the objectives to be met, specific actions that will be taken, party or parties who will be responsible for implementing the various parts of the plan, and timeframes within which objectives will be accomplished.

Readiness Assessment Questions

The following are examples of the types of vision and strategic planning questions that a community can ask in assessing its readiness and capability to undertake substance abuse prevention activities:

- Is there a vision that embraces drug abuse prevention?
- Who has the vision? How widely is the vision shared?
- How do members of the community perceive the vision?
- Will the community support the vision?
- Are there people with planning skills available? Do they have the time, talent, resources, willingness to act to develop and implement the program?
- Are community members, for example, parents and youth, willing to contribute to the planning process by participating in needs assessment activities and supporting the implementation of the plan?
- Are there local evaluators who can be involved in the planning process to help design the plan and ensure that appropriate and measurable program objectives are identified?
- Are the approaches/methods implied by the vision logical? Are they consistent with research findings on effective strategies?
- Are the approaches suitable for the target population?
- Is there evidence that the risk and/or protective factors addressed by the proposed prevention approach match those in the target population?

A community's vision for substance abuse prevention programming may be as simple as a desire to see penalties increased for violations of laws prohibiting driving while under the

influence of alcohol or other drugs. Or they may be as complex as the desire to eliminate substance use among all youth under the age of 18. However, the essential factor of a community's vision is that it is shared by the major segments of the community, that is, the major stakeholders who have a vested interest in seeing the vision realized and will represent the driving force behind the effort to achieve it.

Key Factor 5: Energy to Mobilize and Sustain Prevention Activities

An assessment of community readiness also can determine the ability of the community to mobilize its members to begin prevention efforts as well as to maintain them over time. Considerations in any readiness assessment include the energy and commitment of initiators in planning and developing the prevention approach and recruiting and retaining the staff, volunteers, and program participants. The time, energy, benefits, and costs of participation all can be assessed.

Readiness Assessment Questions

Examples of questions that can be addressed in assessing the ability of a community to mobilize and sustain prevention activities include the following:

- Is the community motivated/committed to addressing the problem? Is there long-term commitment?
- Are primary stakeholders involved?
- What events have mobilized the community?
- Are there leaders with energy, time, and talent?
- Are there community members with energy, time, and talent?
- What barriers are there to participation (e.g., intimidation by drug dealers, denial of the problem, time commitment, cost, accessibility)?
- What benefits can be offered people for becoming involved (e.g., information-sharing, increased networking and new friendships, personal recognition, increased knowledge and skills)? What do people want to get out of their involvement?
- Can prevention providers interested in participation have their job duties redefined to allow for greater participation?
- Is the effort likely to be sustained after the initial excitement dies down?
- Will resources be available over time or diminish radically when any major funding ends?

It has been observed that prevention efforts that are strongly desired by the community in general, not just the prevention providers and primary stakeholders, are the ones that last. Although the nonprofessional members of the community and parents often need prevention

professionals to help them make their dreams a reality, it is the commitment of the community that makes a program endure. Solutions to drug abuse problems that are imposed on a community by external forces, for example, funders or researchers, are less likely to be maintained once the external force is no longer present. One example of this type of circumstance was a coalition approach in a community where it was observed that after the Federal funding ended, the only prevention approaches still being implemented were those strongly supported by the community, not necessarily those advocated by policymakers.

Key Factor 6: Networking With and Support of Stakeholders

To make changes in any community, it is important to involve the community leaders, that is, those persons who have a direct stake in the community, before attempting to mobilize the citizens. New substance abuse prevention programs must have the blessing of the community leaders to be successful in attracting staff as well as participants in the prevention activities. Two important issues in community readiness are involved in this aspect of the assessment: a belief that improvement is possible and a willingness to act.

A belief that improvement is possible is difficult to assess from existing resources. Nevertheless, a careful review of newspaper and magazine coverage, and television and radio commentaries or news reports can suggest trends. For example, explanations of the causes of drug abuse might include discussions of causes that can be addressed through community action. Editorials, both print and broadcast, often will be the best indicators of whether local sentiment about drug abuse is hopelessness or willingness to act. Radio and especially television stations often are eager to document their community-mindedness and civic responsibility and will allow reviews of their programming logs. Letters to the editor also can be reviewed for indications of public opinion trends, such as whether concern about a problem is growing, stable, or declining.

It may be worthwhile to telephone local religious leaders or the program chairs of local civic clubs to ask whether sermons or public speakers within the last year have addressed the need for action against drug abuse. The weekly program calendars of civic and religious events in major newspapers and community newsletters may provide valuable indicators of public opinion, as well as the names of potential program supporters. A community may want to determine whether there is widespread skepticism about the effectiveness of prevention efforts or whether doubts exist that they can work in the community.

Belief that change can occur also can be assessed through the use of focus groups, a survey of key leaders, and community attitudes surveys. A random sample of citizens can be selected and approached in different ways, for example, directly in their homes, in group settings, on the street or in other public places, by telephone, or by mail, to solicit their opinions about the problem. Each of these techniques has its advantages and disadvantages. However, it is best to consult a survey research consultant when planning to gather community survey information. A

community needs to assess what attitudes about the problem are apparent, that is, hopelessness or a willingness to mobilize and act.

The existence of a willingness to mobilize to address substance abuse problems can be assessed through a variety of data-gathering methods. A community can look for signs that there are ad hoc neighborhood efforts to organize for action. There may be existing community groups that are devoting at least some attention to the drug abuse problem, and some civic groups and local religious congregations may have had programs that focused on the problem.

Alternatively, a lack of willingness to act also needs to be assessed. For example, some communities may want to launch new efforts at substance abuse prevention, but there may be deterrents on the willingness of the citizens to act, such as personal fears of involvement (e.g., threats of personal injury or death, possible loss of friendships, fear for safety of family), lack of time (i.e., concern that the time commitment will interfere with other obligations to jobs, family, or friends), or concern that they have nothing to contribute to the prevention effort in terms of useful skills, competencies, or resources.

Readiness Assessment Questions

Examples of questions that can be asked to assess the willingness of community stakeholders to mobilize to support prevention efforts include the following:

- What *ad hoc* neighborhood groups exist in the community that could become part of the effort?
- What other community organizations should/can be included?
- Does the effort have the blessing of key leaders?
- Is the prevention effort likely to have support from leaders of other organizations?
- Do leaders believe in prevention? Do they believe that improvement is possible?
- Do the stakeholders believe that prevention works?
- What types of prevention approaches do they believe work or not work?
- Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another?

Key Factor 7: Talent; Leadership Structure; Sense of Community

The type of organizational leadership structure selected for the implementation of a prevention program will depend to a great extent on the existence of a sense of community (see previous chapter for more information). A sense of community is an important factor related to community readiness (Chavis and Wandersman 1990) and contributes to the establishment, maintenance, and value of a strong local leadership structure. McMillan and Chavis (1986) have concluded that people are more likely to participate in a community prevention effort when:

- They feel that they belong to the community;
- They share similar values and goals with the community;
- They feel that they can influence the community; and
- They share an emotional or spiritual connection with others in the community that has developed through a history of working together for common goals or some significant shared event.

Readiness Assessment Questions

Examples of the kinds of questions that can be asked to assess the sense of community and the type of leadership structure that would best support a community prevention program include the following:

- Are community members civic minded?
- Are there key leaders willing to act?
- Do leaders have the power and organizational capabilities needed?
- Can the leaders establish and maintain a prevention program?
- How homogeneous is the community?
- To what extent do community members share the same values?
- Is there a strong sense of community, with members feeling they want to preserve or create a drug-free community?
- Does the community have any history of working together?
- How stable is the community? Are there:
  - Long-term residents?
  - Homeowners?
- What leadership exists in the community?

Models of leadership structures for prevention activities can vary from a professional model to a grassroots volunteer model. (These models are described in the following chapter in the discussion on choosing an organizational structure to increase community readiness.) In practice, most prevention programs involve a combination of both professionals and volunteers. If there is little sense of community or history of community volunteerism, it will be difficult to implement a grassroots organization successfully; if the prevention program lacks representation from the community it serves, it may fail. It is particularly important to include opinion leaders from the community—people others in the community trust and turn to for advice.

Matching the Program to the Community Context

The foregoing discussion has provided a framework for assessing community readiness for substance abuse prevention. All these community readiness factors should be assessed *before* a community attempts to implement a prevention program. If all of these factors are found to exist within the community, and the program is implemented, then the program will have a greater likelihood of being implemented as planned and of being successful in addressing the community's drug abuse problem. Nothing spells doom for a prevention effort more than an attempt to implement the effort in a community that is not ready. However, often the community that is most acutely aware of a problem is the one that is least likely to have the other necessary readiness factors to successfully implement a prevention effort. A community overwhelmed by substance abuse and other problems often finds it difficult to mobilize its citizens to act or garner the necessary resources for the effort. In practice, most communities fall somewhere between extreme need and minimal readiness on the one hand and minimal need and great readiness on the other, thus, the need for an objective assessment of a community's readiness.

Once a community has been assessed and deemed ready to proceed with prevention programming, it is still not enough to select a specific substance abuse prevention program to implement simply because that program was found to be effective in another community. To have an effective prevention program, a community must match the program to the community's characteristics and local needs. Excellent programs have failed because of a mismatch with the social or political circumstances of the community. Research suggests that model programs are more likely to be adopted, implemented, and maintained when they are consistent with existing organizational practices or culture (Rogers 1983; McLeroy et al. 1993). In addition, programs are more likely to be adopted and maintained when they can be modified or adapted to the local community needs and become an integral part of the agency or organization that sponsors them (Steckler et al. 1992).

When selecting a prevention program, prevention practitioners must understand and be sensitive to a community's norms and degree of readiness to accept the particular program. They also must ensure that their understanding of the substance abuse problem matches the problem as experienced by the residents of that community. Prevention practitioners also can assess and build

the capacity of the community to maintain the prevention effort and not just provide short-term services. Minkler (1989) and others have suggested that increasing the capacity of families, social networks, neighborhoods, organizations, and communities to solve their own social and health problems can be the goal for prevention practitioners. Prevention programs that are adopted by a community can support but cannot become a substitute for a community's ability to solve its own problems (McLeroy 1993).

Sometimes a mismatch can occur between external funding and community readiness. Occasionally a community may receive funding for drug abuse prevention efforts on the basis of a well-developed proposal that was created by a writer who was hired from outside the community. In such a case, the writer may overstate the involvement of community members in the prevention program planning process. Then if the community does not support the prevention approach or does not trust the program implementers, the program may fail. One example of a poorly planned prevention effort that was not sensitive to the needs of the community was a program proposed by researchers at a major university. The researchers proposed creating a parenting clinic for inner-city mothers that would be housed at the university's research facilities. When the proposal was funded, none of the mothers targeted for the program would participate. Had the researchers interviewed the parents in the target population prior to selecting the prevention program approach, they would have learned that the parents did not trust the university, did not like the intimidating research facility, and did not believe that they needed to improve their parenting skills. In this instance the community clearly was not ready to initiate that particular type of prevention effort.

In some cases, communities may be poised and ready to mobilize or may already be mobilized but lack a number of other key community readiness factors that would allow them to proceed with effective prevention activities. A community is not ready for prevention if it:

- Lacks a clear definition of the problem and/or recognition of a need for the proposed program;
- Denies substance abuse problems exist and/or a need for substance abuse prevention programming;
- Lacks support of primary stakeholders and resources to attract funding and participants, staff the program, and house the program;
- Lacks vision or opposes the particular prevention activities proposed;
- Lacks resources to sustain the prevention program after the external funding end;

- Lacks a sense of community and togetherness; and

- Lacks capable leadership or has leaders who are apathetic or intimidated.

The following are hypothetical examples of how these community readiness deficiencies can compromise prevention efforts:

- *Lack of problem definition*. A community agency serving female drug abusers wanted to implement a prevention program for the children of their clients but did not have enough information about the extent of the problem among the target children to convince funders to support the proposed prevention approach.

- *Denial of substance abuse problems by the community*. A community prevention agency did everything right in involving the community in developing a proposal for a comprehensive prevention program but failed to attract funding because it could not overcome the pervasive perception in the local community that the targeted population did not have substance abuse problems.

- *Lack of support by primary stakeholders*. An ethnic community ready and committed to act to reduce drug problems was not funded by its local drug abuse prevention coalition because the funding agency did not agree that substance abuse problems in that particular ethnic community were its highest priority.

- *Lack of ability to attract needed community resources and funding*. Several multiethnic gang- and drug-ridden neighborhoods that were mobilized primarily by parents failed to receive major Federal funding because the parents lacked the capability to write a convincing proposal to attract needed funds.

- *Lack of a community-supported vision or plan*. A coalition of city leaders and community drug prevention providers serving a low-income neighborhood built a new youth services center but did not consult the parents of the youth concerning the perceived safety of the location; hence, few youth ever came to the center.

- *Lack of energy to mobilize and sustain the prevention activities*. A school-based coalition developed by several teachers operated successfully for about 2 years but failed when significant burnout was experienced by the core leaders who actively participated in the prevention activities in addition to meeting their full-time teaching responsibilities.

- *Lack of a strong leadership structure and sense of community*. A dedicated grassroots community and provider planning group in a public housing

neighborhood worked hard for 2 years to mobilize a fragile, disconnected, and disenfranchised community, only to have their most prominent leaders drop out after receiving death threats from local drug dealers.

It is clear from these examples that many elements of readiness must be addressed if prevention programs are to be planned and implemented successfully. There may be instances in which many different prevention programs are operating simultaneously within a given community, but for each program to have the best chance of success, all the community readiness factors should be present. Although it is reasonable to conclude that some key readiness factors may have greater importance for some types of prevention programs than other factors, the research on community readiness does not yet make it possible to identify precisely which key factors are more or less important for which types of programs.

This chapter has focused on the assessment of factors associated with readiness for successful drug abuse prevention programming. Exhibit 5 contains a readiness inventory that summarizes the assessment questions asked regarding each factor. Exhibits 6 through 8 contain vignettes illustrating the assessment of readiness in different communities. The next chapter discusses strategies that communities can use to improve readiness in areas determined to be deficient. Appendix B contains a detailed case study of a large-scale effort illustrating how readiness can be assessed and programs developed based on the assessment.

Exhibit 5

COMMUNITY READINESS INVENTORY

1. PROBLEM DEFINITION

Assessment Questions	Information Sources	Findings and Recommendations
• What risk factors are present (e.g., transient population, norms supporting drug abuse, drug dealing/crime, absence of alternatives, disorganization)?		
• What types of drugs are abused?		
• By whom?		
• Where in the community does drug-abusing behavior occur?		
• What data are available about the nature and extent of the local drug problem?		
• What new data can be collected?		
• By whom?		
• Who will fund the data collection?		
• Is drug abuse tolerated in some areas?		
• What protective factors are present?		
• What prevention activities already exist? What are the gaps in services?		
• What areas (or groups) of the community are most affected by substance abuse?		
• Has any previous needs assessment been conducted that could provide information?		
• Where could the community intervene most effectively to address the problem?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

2. RECOGNITION OF PROBLEM BY COMMUNITY

Assessment Questions	Information Sources	Findings and Recommendations
• To what extent does the community believe there is a drug problem?		
• What are the perceptions of the drug problem? How accurate are they?		
• Has there been an event or incident that has aroused concern?		
• How do key leaders perceive the drug problem?		
• How are drugs portrayed by local media?		
• Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?		
• How often do stories disclose the consequences of drug-abuse-related problem behaviors?		
• What types of drug abuse problems are currently reported?		
• What are perceptions of the causes of/possible solutions to the problem?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

3. EXISTENCE OF AND ACCESS TO RESOURCES

Assessment Questions	Information Sources	Findings and Recommendations
• What human resources are available to staff a prevention project (e.g., professional, volunteer, other)?		
• How much time can they commit?		
• What facilities and equipment are available to support the effort?		
• What potential funding exists for the effort (e.g., Federal or State grants, private foundations or corporations, agencies)?		
• What *pro bono* help is available (e.g., legal, accounting, advertising, research design/evaluation)?		
• What in-kind services are available (e.g., word processing, duplication, mail, telephones, computer time, other)?		
• Can funds be redirected from or combined with those of other programs to address the drug problem?		
• Are prevention services providers, as well as community volunteers, willing to commit additional time to the program effort if funds are limited?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

4. VISION AND PLAN

Assessment Questions	Information Sources	Findings and Recommendations
• Is there a vision that embraces drug abuse prevention?		
• Who has the vision? How widely is the vision shared?		
• How do members of the community perceive the vision?		
• Will the community support the vision?		
• Are there people with planning skills available? Do they have the time, talent, resources, willingness to act to develop and implement the program?		
• Are community members, for example, parents and youth, willing to contribute to the planning process by participating in needs assessment activities and supporting the implementation of the plan?		
• Are there local evaluators who can be involved in the planning process to help design the plan and ensure that appropriate and measurable program objectives are identified?		
• Are the approaches/methods implied by the vision logical? Are they consistent with research findings on effective strategies?		
• Are the approaches suitable for the target population?		
• Is there evidence that the risk and/or protective factors addressed by the proposed prevention approach match those in the target population?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

5. ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES

Assessment Questions	Information Sources	Findings and Recommendations
• Is the community motivated/committed to addressing the problem? Is there long-term commitment?		
• Are primary stakeholders involved?		
• What events have mobilized the community?		
• Are there leaders with energy, time, and talent?		
• Are there community members with time, energy, and talent?		
• What barriers are there to participation (e.g., intimidation by drug dealers, denial of the problem, time, commitment, cost, accessibility)?		
• What benefits can be offered people for becoming involved (e.g., information-sharing, increased networking and new friendships, personal recognition, increased knowledge and skills)? What do people want to get out of their involvement?		
• Can prevention providers interested in participation have their job duties redefined to allow for greater participation?		
• Is the effort likely to be sustained after the initial excitement dies down?		
• Will resources be available over time or diminish radically when any major funding ends?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

6. NETWORKING WITH AND SUPPORT OF STAKEHOLDERS

Assessment Questions	Information Sources	Findings and Recommendations
• What *ad hoc* neighborhood groups exist in the community that could become part of the effort?		
• What other community organizations should/can be included?		
• Does the effort have the blessing of key leaders?		
• Is the prevention effort likely to have support from leaders of other organizations?		
• Do leaders believe in prevention? Do they believe that improvement is possible?		
• Do the stakeholders believe that prevention works?		
• What types of prevention approaches do they believe work or not work?		
• Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

7. TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY

Assessment Questions	Information Sources	Findings and Recommendations
• Are community members civic minded?		
• Are there key leaders willing to act?		
• Do leaders have the power and organizational capabilities needed?		
• Can the leaders establish and maintain a prevention program?		
• How homogeneous is the community?		
• To what extent do community members share the same values?		
• Is there a strong sense of community, with members feeling they want to preserve or create a drug-free community?		
• Does the community have any history of working together?		
• How stable is the community? Are there: — Long-term residents? — Homeowners?		
• What leadership exists in the community?		

LOW	MOD	HIGH
READINESS		

Exhibit 6
Vignette #1

Citywide Prevention Program
Sunnyville

Sunnyville is a city with a population of approximately 650,000 located more than 200 miles from the next city. Because of economic expansion, the city has spread to encompass some small towns that had been on the outskirts. The economy is largely agricultural with some light manufacturing and a growing electronics industry; there is one university and two colleges. The population is predominantly white, with small percentages of African-Americans, Hispanics, and American Indians. There also is a growing Asian population, mostly recent immigrants from Southeast Asia.

Historically, the community has not perceived much of a problem with drug abuse. Although there has been some heroin and cocaine abuse, it has been restricted to certain neighborhoods characterized by high mobility and a transient population, including seasonal farm workers; low income families; and generally more crime than in the rest of the area. Recently, there was an incident in which a high school youth from an upper-middle-class family died from butane inhalation while at a party. Investigations of the death produced many anecdotes of recreational drug abuse, particularly inhalants, such as Glade and Scotchguard, but also some marijuana and LSD. This information has caused some alarm among parents and has captured the media's attention. However, city leaders believe the incident was an aberration and that there is no serious drug problem. They believe funds are better spent on economic development, which will benefit everyone, rather than on drug prevention. Parents and community members express some confusion; it is not clear to them whether there is a serious drug problem.

There are a few isolated programs that provide drug prevention services in Sunnyville: a YMCA, a couple of church programs, and an afterschool program. Once a year the police visit each school to make a presentation on drugs. In addition, drug prevention topics are covered annually in health classes.

Concerned parents in the neighborhood where the death occurred have organized and conducted an assessment of the city's readiness to launch a major prevention effort. The results were:

Problem	There is little factual information about the type or extent of drug abuse in the community—only anecdotal evidence. There is no process in place for tracking drug trends.	**LOW Readiness**

Exhibit 6
(Continued)

Recognition	City leaders do not believe there is a problem, and other community members are unsure.	**LOW Readiness**
Existence of Resources	There are good resources: There are already some programs in the area poised to provide services. The university and colleges have faculty and students available to support the effort. There are several professional organizations available to provide support, either through donations or in-kind contributions.	**HIGH Readiness**
Vision	There is generally a vision of what the community should be, and the organizers have a vision for the prevention program; however, there is no communitywide common shared vision. However, there are good planners available to help develop a plan.	**MEDIUM Readiness**
Energy	The community has many long-term residents with a history of involvement. They have successfully organized before to establish a sex-education program in the schools.	**HIGH Readiness**
Networking	The community has several existing organizations that could support the effort.	**MEDIUM Readiness**
Talent/Leadership	There are several leaders among those who have organized and many strong candidates elsewhere in the community.	**HIGH Readiness**

Based on this assessment, the organizers concluded that they should focus on increasing the community's readiness by gathering more information about the problem and working on building awareness. Once armed with facts, the organizers believe they will be able to convince leaders that a problem exists. If they have the support of top leaders, they believe they can mobilize the community and enlist the help of the existing organizations.

Although it is premature to be planning which model of prevention to implement—universal, selected, indicated, or a combination—the organizers think a universal program may be most appropriate initially. The results of the needs assessment will give them clearer information about what type of program would be most suitable for the community.

Exhibit 7
Vignette #2

Neighborhood Prevention Program
Southside

Southside, a suburb of Sunnyville, has a long history of substance abuse problems. The community has many long-term residents who own their homes. However, the homes and neighborhoods are run down. A lot of drug activity is clearly visible to youth, including sales of drugs. Incomes are low; crime is high; gang activity is increasing. Some of the population is transient. Long-term residents abhor the changes they have seen in their neighborhood but feel powerless to do anything about the growing problem. They have never organized before.

There is a church program and a YMCA program that try to offer alternatives to youth. The school counselor has become frustrated by the problems he has seen and has approached the church and the YMCA to discuss setting up a program in the neighborhood.

Because of the neighborhood's characteristics, residents believe all the youth living in the area would benefit by a program; but they are particularly concerned about reaching youth who are performing poorly in school, have had some behavioral problems, or otherwise exhibit risks associated with substance abuse.

A team of residents has conducted a readiness assessment with the following results.

Problem	The problem is fairly well understood in this neighborhood, and there are good statistics available on who is most at risk—for example, attendance records, grades, probation records.	**HIGH Readiness**
Recognition	Members of the local community are well aware of the drug problem.	**HIGH Readiness**
Existence of Resources	There are few resources available in this poor neighborhood—no professional businesses to provide *pro bono* services, no corporations to make donations, and few people with the time and energy to volunteer.	**LOW Readiness**
Vision	The team has a strong vision, but no one on the team has planning skills or experience.	**MEDIUM Readiness**
Energy	The community doubts its ability to mobilize and has no history of organizing.	**LOW Readiness**

Exhibit 7
(Continued)

Networking	The team has a strong informal network with the various organizations but no strong links with city leaders who would be able to help the cause.	**MEDIUM Readiness**
Talent/Leadership	There are a couple of strong leaders available on the team but they lack some of the expertise needed for the job.	**MEDIUM Readiness**

Based on this assessment, the team has concluded that it needs to work on building a stronger base before starting a prevention program. It will start by getting leaders trained in planning techniques and prevention strategies. Then the team will work on building stronger ties among organizations in the community. The team is considering a fundraising strategy that would use neighborhood volunteers. It would be comparatively easy to organize and would give community members an opportunity to work together; most important, it would give a sense of success and achievement, which would strengthen the community's energy to mobilize.

Team leaders are fairly certain they want a universal program aimed at all youth in the neighborhood; however, they also want a selective program targeting students in junior high who are at risk because of truancy, poor grades, family situation, or association with substance abusers.

Exhibit 8
Vignette #3

School Program
Matthew Arnold High School

Matthew Arnold High School is located on the border between a wealthy, upper-middle-class neighborhood and a much poorer neighborhood. Because of the strong tax base in the wealthier neighborhood, the school has money for special programs, equipment, and materials. The school superintendent has urged the principal to implement a drug program, and the PTA strongly supports it. In response, the principal has appointed a task force of teachers, parents, and the school counselor to plan a program. The task force decided to start by conducting a readiness inventory.

Problem	There are good data available on students at risk for drug abuse by virtue of where they live, association with students who use drugs, history of behavioral problems, truancy, and poor or dropping grades; in addition, data is available on students who are on probation for crimes such as shoplifting. There is little information available about the drug abuse patterns and needs of the total student population, but a small group of students is known to use drugs.	**MEDIUM Readiness**
Recognition	There is general agreement that a prevention program is needed and awareness that some students already are abusing drugs.	**MEDIUM Readiness**
Existence of Resources	There is money as well as facilities for a program. However, staff are already fully committed, and there is no one with the time to take on the additional responsibility of planning and running a prevention program. Nor is there anyone with the formal training that might be required.	**MEDIUM Readiness**
Vision	People know they want to do something but are unsure of what. There are resources, but it is unclear how they should be used or who can actually plan and implement the program.	**LOW/ MEDIUM Readiness**
Energy	There is plenty of interest among parents, teachers, students, and others, including the police department.	**HIGH Readiness**

Exhibit 8
(Continued)

Networking	The entire school community has given its support to the project—the superintendent, principal, parents, and police.	**HIGH Readiness**
Talent/Leadership	Although there are many leaders involved, none of them has the time to commit to the project.	**LOW Readiness**

The biggest problem in this school is finding someone with the time and knowledge base needed to run an effective prevention program. The task force believes an indicated program focusing on students already involved with drugs might be the best starting place, but such a program will require at least one full-time teacher/counselor. The PTA also wants a universal program to educate all students on the dangers of drug abuse.

After completing the readiness inventory, the task force recommended to the principal one of two courses of action: (1) reorganize to free up talent to run the program or (2) recruit a drug prevention education/counseling specialist to run the program. However, before taking any action, the task force recommends a weekend planning retreat to decide definitely on the goals of the program. It recommends hiring an outside consultant with planning expertise to facilitate the planning session.

IMPROVING COMMUNITY READINESS

The seven key factors presented in the previous chapter address the elements of community readiness and ways to assess the readiness of a community to implement prevention activities to reduce substance abuse. But what happens when it is determined that one or more of the factors is weak, for example, when the community is not ready, and work is needed to increase community readiness before a prevention effort can begin? This chapter describes steps that a community can take to improve or increase each readiness factor to implement prevention strategies successfully.

In the previous chapter, a variety of techniques were identified for assessing each key factor associated with community readiness. However, it is important that the reader understand that many of these techniques can be used to assess as well as improve more than one key readiness factor. For example, information acquired through surveys of key community leaders and assessments of the local print media also can help improve the definition of the local substance abuse problem, increase the community's recognition of the problem, and increase the support of the primary stakeholders in the prevention effort. Therefore, if prevention program implementors can begin to recognize the broad utility of their data collection strategies and information, they can achieve a greater impact from their data collection efforts and dollars.

The discussion of the following steps for improving community readiness is presented in a specific order to correspond to the seven key readiness factors in the preceding chapter. The intention is not to focus on the order in which a community should tackle deficient factors but on the specific actions that a community might take to improve a particular key readiness factor that, on assessment, was found to be deficient. The following strategies can be used to improve readiness:

- Step 1. Conduct a Community Substance Abuse Needs Assessment
- Step 2. Increase Problem Recognition
- Step 3. Access Community Resources
- Step 4. Develop a Strategic Plan
- Step 5. Maintain Momentum
- Step 6. Mobilize the Community
- Step 7. Choose an Organizational Structure

Step 1. Conduct a Community Drug Abuse Needs Assessment

If it is determined that there is no clear definition of the substance abuse problem within the community, there are specific strategies that can be used to strengthen this important readiness factor. A community's need for a substance abuse prevention effort can be determined from primary and secondary data sources. Primary data sources include those from which information is gathered directly from individuals through such mechanisms as focus groups, attitude and opinion studies, and epidemiologic surveys. Secondary data sources are those from which information is gathered through review of data that have been collected and are maintained by various governmental and/or other community service agencies. In practice, using secondary data sources may be difficult for nonprofessional community members. For example, unless these efforts are associated either with those of recognized community officials or prevention professionals, community members may find access to existing data sources hindered or blocked by agency procedures. Access to data in agency files also can be hindered by the amount of staff time required to retrieve and assemble the data in a usable format. However, there are several important sources of collectible data that communities can tap.

Primary Data Sources

A preliminary understanding of the nature and extent of a local substance abuse problem can be achieved through the collection and analysis of data that are gathered through mechanisms such as focus group discussions and face-to-face meetings with concerned professionals, surveys of key community leaders and other members of the general population of the community, and analyses of the community's print media. These sources of data can provide a wealth of information about the perceptions local residents have of the drug abuse problem and can answer important questions about who has the problem, the existence of possible unreported or undetected users, and the social context in which the problem occurs. These kinds of data also can help a community determine the reasons the respondents think certain persons use drugs and how they think the drug abuse problem could be solved or reduced. Several primary sources for data collection include:

- Focus groups;
- Needs assessment surveys;
- Community attitudes and opinions surveys;
- Key leader surveys; and
- Print media assessments.

Focus Groups

Individual face-to-face or telephone interviews provide a useful means for accessing information that respondents may not want to share with other members of the community or information that may be of a confidential nature. However, these types of interviews can be expensive and timeconsuming. Therefore, focus group discussions with 8 to 10 participants at a time, representing professionals, community leaders, and members of the general public, provide an alternative mechanism for getting necessary information. Although confidential information may be more difficult to obtain in focus groups than in individual interviews, focus groups nevertheless do have advantages. For example, when several participants are asked to address the same questions in a group situation, all are able to share their perspectives on the problem, learn about the perspectives of other community members, learn how their understanding of the problem may be the same or different from that of their neighbors, and react to opinions expressed by others. One of the chief advantages of focus groups is that they foster interactions among participants that sometimes yield insights that could not be obtained through other means.

Much literature on conducting focus groups exists, although it is directed primarily toward applications in commercial marketing and political campaigns. However, the Center for Substance Abuse Prevention (CSAP) has published two four-page factsheets of tips on how to conduct focus groups (*The Fact Is . . . You Can Manage Focus Groups Effectively for Maximum Impact*, and *The Fact Is . . . Conducting Focus Groups With Young Children Requires Special Consideration and Techniques*), available through NCADI. See appendix A for further information. Conducting a focus group is different from conducting a meeting or panel discussion. Therefore, if professional direction is not available, volunteer leaders should be trained by a professional on the basic dynamics of focus group interaction. Advertising agencies and marketing consulting firms usually can be productive sources of information on conducting focus groups.

Needs Assessment Surveys

Needs assessment surveys are an extremely important method for collecting information that can be used for developing immediate community involvement and raising public awareness of the need for substance abuse prevention. There are several types of surveys that can be conducted to assess community needs depending on the time, money, and other resources available to develop appropriate survey instruments. However, conducting a needs assessment can be a difficult process. Therefore, it is a good idea to solicit advice from professionals who are experienced in designing and conducting needs assessments. A good place to start is with the research staff of the local county or State substance abuse agency. They are familiar with survey sampling methods and questionnaire construction and are able to identify other experts at universities or private companies who could assist the process. There are several different types of needs assessment methods that a community might use. These include direct surveys of community attitudes and opinions and surveys of key community leaders.

Community Attitudes and Opinions Surveys

These are surveys that are conducted for the purpose of soliciting the opinions and measuring the attitudes of community residents about particular issues or topics. The types of people who can be surveyed include residents and community service providers, such as physicians, nurses, social workers, and drug abuse treatment providers. They will be familiar with many of the important aspects of local substance abuse problems. A survey of community perceptions about local problems and needs will yield several important dividends. In addition, a survey of community perceptions can be designed to gather information needed to better interpret the meaning of other existing data. A direct survey of community members can, for example, shed light on the reasons they think their youth are dropping out of school and using drugs.

Community attitude surveys can have multiple uses to assess the presence of several community readiness factors. For example, the survey can address community readiness factors such as level of sense of community, beliefs that prevention can work, level of concern, willingness of community members to volunteer, barriers to participation, and reasons about the causes of the substance abuse problem. In addition, community surveys can be used as a baseline against which to measure success in changing public attitudes and increasing public awareness by comparing the results of an initial survey with the results of a survey that is conducted after a public awareness campaign.

Community surveys can be administered in several ways: by mail, by telephone, and in person (e.g., house to house, on the street or in groups). Each method has advantages and disadvantages. In general, mail surveys take longer to collect and have a low response rate because respondents often do not return the survey. However, the cost per response to conduct a mail survey is low relative to other methods. Problems arise with telephone surveys because community members who do not have telephones are excluded from the survey population, and therefore any information from the survey will be biased. Household surveys generally can be expensive unless they are conducted by trained but unpaid volunteers. A needs assessment advisor can help community members determine the best method to use for their particular situation. A guide for reviewing survey methods and community survey instruments, such as *Measurements in Prevention: A Manual on Selecting and Using Instruments to Evaluate Prevention Programs* also can be helpful (see Appendix A).

A community survey will indicate what aspects of substance abuse are perceived by the community as pressing problems. This information is essential for enlisting community participation. The mere fact that a survey is being conducted will of itself be local news, especially if a broad spectrum of community associations, churches, clubs, and other organizations is involved in administering the survey. Conducting the survey also

raises community awareness. Specific information about the local community, especially as it compares with State and national data, will have immediate news value. It will provide a productive basis for initiating contacts with local print and broadcast media. A final advantage of a community survey is that local prevention providers will be seen as coming to the community with questions and not with a predetermined prescription for *what this community needs*. A willingness to listen on the part of surveyors helps solve problems and gain goodwill.

Key Leader Surveys

Surveys of key leaders within the community have advantages similar to those of direct surveys of community attitudes and opinions. A survey of key leaders can include key elected and appointed officials, heads of civic and business organizations, prominent business executives, and religious and educational leaders. The key leader survey is usually best conducted as a series of structured interviews carried out by senior members of agency staff or by members of a community drug abuse prevention advisory board. Key leaders are busy people; therefore, requests for appointments with them should be explicit as to the purpose of the interview, the organization sponsoring the survey activity, and the amount of time that will be required to complete the survey. It is important to remember that the more senior and influential the leaders, the less time they will likely have to devote to the task. Interviewers should be prepared to listen and really hear what the leaders have to say. People who are accustomed to being listened to may be quickly alienated if it appears that someone has come to educate them.

Interviewers can ask respondents to identify others within the community who also are working on the problem, who else can be contacted as part of the survey, and where else the interviewer can look for relevant information. By explicitly asking these types of questions, the interviewer will often discover important referrals to other data sources.

Finally, during the interview process, the interviewer also can compile a list of private associations and public and private agencies directly or indirectly concerned with substance abuse, associated problems, or relevant target populations. This information later will be essential for determining how well needs are being met and what gaps in services still exist. It is useful for increasing access to community resources and in the community strategic planning process.

Print Media Assessments

A survey of local newspapers, magazines, newsletters, and other forms of popular media can help define the drug abuse problem within a community. For example, some events, like robberies, are likely to involve physical harm beyond the drug abuser and affect innocent third

parties. How such situations are reported by the media will help determine how the problem is perceived within the community. Drugs and alcohol may be identified as the causes or major contributors to automobile accidents, spouse or child abuse, assault, or use of violence during robbery or burglary, and gang activities may be related to the sale of illegal drugs. Whether an event becomes a watershed event in community awareness is related as much to previous community experiences as to the severity of the event. For example, detection of possession of marijuana in a school locker might be a significant event in a small town but may be so routine in a large urban school as to attract almost no attention.

Prevention practitioners and community volunteers conducting needs assessments can maintain logs of drug-related stories as an indication of the types of drug abuse problems that are examined by the media. Such logs might note the date, the particular drug involved, whether the offender is an adult or youth, and any related criminal activity. A typical log entry might read as follows: January 17, 1994, crack, youth, stabbing at party. A review of the log often will show a pattern in press attention and thus public concern. However, this may not necessarily correspond to actual drug use. Press attention may be directed to a particular kind of local activity, for example, a police drug raid, or to national trends or events, such as National Red Ribbon Day. Media assessments also may identify geographic locations of drug incidents or the gender, ethnicity, or other demographic characteristics of persons involved in the incidents.

Finally, what media articles suggest about the causes of drug abuse problems and their possible solutions will be additional information that a community can use. This type of information often will appear toward the end of an article; after the writer has addressed the who, what, when, where, why, and how, he or she concludes with human interest material to complete the story. The reporter's speculations may be unscientific, but often they will reflect local assumptions about why these sorts of things happen. A content analysis also may be performed on local news stories and other media coverage to determine how much coverage there is, how drug stories are portrayed, and the general tone. This kind of analysis can show trends and also yield important insights into local perceptions of the problem.

Secondary Data Sources

One of the first steps in a community needs assessment is to determine what data already exist that would help define the extent, nature, and location of the substance abuse problem. Existing data from prior household, school, business, and community surveys or agency records are classified as social indicator data. These include:

- Census data;
- Agency annual reports;

- Social and health statistical records;
- Police records;
- Social service, health, and mental health agency records; and
- Educational system records.

Census Data

Census data are available through State and county planning offices and public and university libraries. These data provide valuable information about the characteristics of the population that are relevant to the drug abuse prevention effort. State or county planning agencies may assist communities to analyze census data, using Geographic Information System (GIS) computer software, to determine such factors as the level of substance abuse, number and reasons for arrests, income and education levels, number of single parent families, average size of families, and other demographic correlates of substance abuse by specified neighborhoods within a community. These are only a few of the more obvious examples of useful data that can be collected from census sources, often down to the street or block level of detail. These kinds of data are essential in targeting the largest problem areas for action. This information can be used to choose a neighborhood to work in or determine characteristics of the population, including risk and protective factors, to address in the strategic planning process.

Agency Annual Reports

Reports that address drug abuse problem behaviors are often published or prepared by agencies for purposes of internal review of agency activities. These reports may contain descriptions of the drug problem, providing information on the extent or nature of the problem, including incidence, prevalence, type of drugs used, and characteristics of the users. Schools; Federal, State, and local law enforcement agencies; and health and social service agencies are examples of the types of agencies that are likely to have these kinds of reports.

Social and Health Statistical Records

Statistical records, or fact books, are prepared by some State drug abuse agencies on the extent of alcohol and drug abuse and abuse within different populations within the State. These records also can include information on the extent of social problems related to substance abuse, such as the number of births to unwed mothers, level of poverty, family assistance program utilization, and crisis hotline utilization in a community.

Police Records

Records relating to types and prevalence of crime by neighborhood, such as drug-related crime, delinquency, vandalism, and domestic violence, are important sources of data. State or local police departments often compile criminal activity reports annually by jurisdiction that include such information as drug and alcohol arrests or crimes involving drugs and alcohol, location and time of arrests, and types of individuals involved. Police departments in small jurisdictions may not have these records computerized for easy analysis, but local summary data are often submitted to the State law enforcement agency and then compiled into the Uniform Crime Reports of the Federal Bureau of Investigation. Annual summary reports and some computerized data can be made available to local communities.

Social Service, Health, and Mental Health Agency Records

These types of records and summary reports can provide important detailed information about the population of a community, such as incidence of child abuse and neglect; incidence of domestic violence; number of emergency room, outpatient, and psychiatric hospital admissions by diagnosis including drug and alcohol abuse; and other diagnoses associated with substance abuse, such as depression.

Educational System Records

Information maintained and summary reports prepared by the public school system are sources of data related to standardized test results, dropout rates, truancy, absences, disciplinary actions, school policies, and existing prevention efforts. Data also may be available on student academic performance, such as grade point averages by grade and rates of school failure.

Using Multiple Sources of Data

Data from several different agencies can be combined in one annual report or in municipal yearbooks. Therefore, the data search can begin with the most comprehensive collections of information that are readily available and then work as far down to the collecting agency level as is necessary to capture information that is specific enough for the intended purpose. Data that have not already been compiled by an agency for public dissemination may be difficult or impossible to obtain. In addition, because unpublished data, even if obtained, will frequently be in raw form, that is, not summarized, interpretation may be difficult without significant participation and guidance by staff from the particular agency.

Because the sources of data will be many and relationships among community agencies often complex, the availability of any data mapped by geographic location should be explored with particular care. Geographic mapping, such as GIS data mentioned previously, makes correlation

of data from multiple sources considerably easier and puts the resulting compiled data in the format most likely to be effective in community advocacy efforts.

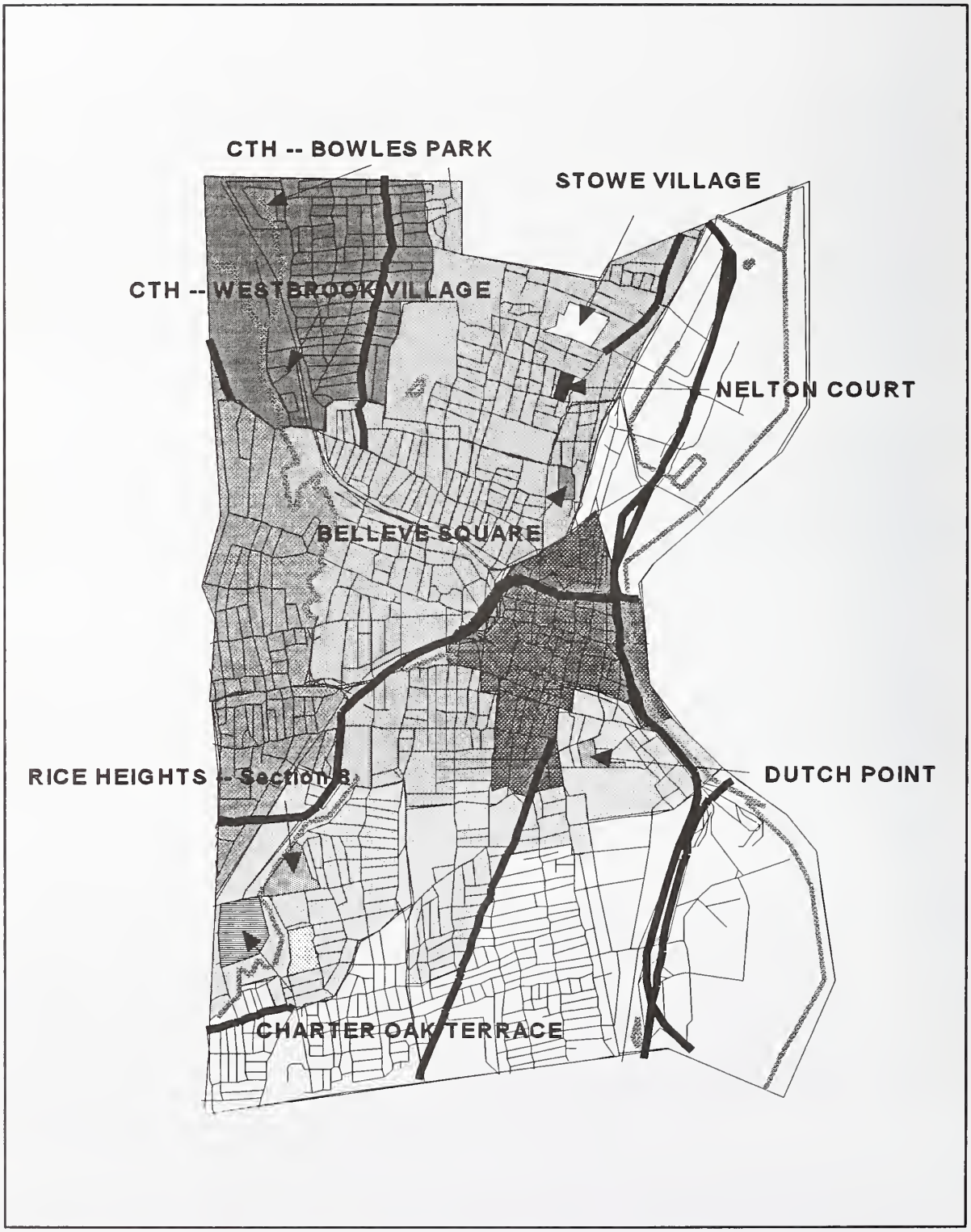
An example of a GIS map created from crime and arrest data is shown in figure 3. This map, prepared for a city housing authority, shows the location of public housing within the city as bounded by streets and neighborhood districts. The darkest shading indicates the highest crime areas; the medium shading shows a lower degree of criminal activity. Applying this example to other communities, areas might be color coded to represent varying degrees of drug- crime severity, ranging, for example, from minimal to extreme. Areas also can be shaded to represent housing areas where the number of gun-related violent crimes occur on the premises of the public housing residences. If desired, the actual pin-point locations of arrests for crimes and drug activity can be illustrated. Likewise, similar data collection performed for health, schools, and social service agencies could be graphically illustrated to help planners determine needs.

Step 2. Increase Problem Recognition

If the key readiness factor of recognition of the problem by the community is determined to be deficient, the results of the comprehensive needs assessment to define the problem can be used to increase community awareness and problem recognition. The needs assessment results will describe the nature of the problem and help provide ideas of what the community can do about it. As mentioned in the previous section, the process of conducting a needs assessment can have a secondary result of increasing community awareness of the problem. Efforts to increase awareness of drug problems, such as public media campaigns, always can be paired with messages of hopefulness, that is, with messages that community action can reduce or eliminate the problem (Arkin and Funkhouser 1990). There are several important steps that a community can take in raising public awareness through media campaigns. These include:

- Creating a communications advisory group;
- Deciding on the message;
- Defining and focusing the message;
- Developing a public awareness marketing plan; and
- Implementing the marketing plan.

Figure 3
GIS Map



Example GIS map of drugs and violent crime offenses in a Northeastern city.

Creating a Communications Advisory Group

The assistance of media professionals is essential to a successful campaign. An advisory group of local communications, marketing, and advertising professionals can be created. Prevention providers should resist the temptation to design the campaign themselves. The time expended in identifying and recruiting concerned professionals will be more than worthwhile. Local television and radio stations, advertising agencies, and associations of communications professionals all will show some willingness to help deliver a public service message of interest in their community. Often, these media outlets will have either a legal or professional responsibility to provide community service that can be met by working on the campaign. An advantage to creating a communications advisory group is that it can increase the involvement of the media in the local prevention effort, involvement that is often lacking but is extremely valuable (Robert Wood Johnson Foundation 1989).

The communications advisory group can be asked to design and target news releases, paid media efforts, and public service announcements. Advisory group members can specifically advise the media about what needs to be communicated and to whom. Specific information can be provided about the attitude change that is desired in the target audience and how to prepare for or produce this change. The media also can be provided specific information about what they can do to support the campaign.

Research by Winsten and DeJong (1989) on media campaigns aimed at substance abuse prevention among youth has shown that there are several important elements that make media campaigns successful. These authors have concluded that the most successful approaches are those that incorporate the following elements:

- Long-term campaigns of 1 year or more starting with a media blitz to get attention and community mobilization;
- Carefully tested media messages of public concern;
- Clearly identified target audiences;
- Messages that build on the current knowledge of the target audience;
- A media plan that guarantees exposure of the target audience to the messages; and
- Extensive use of needs assessment data and research.

Media campaigns in health promotion (Farquhar 1985) and substance abuse prevention (Pentz et al. 1989) are highly successful when used in conjunction with other community substance abuse strategies such as drug education in the schools, parent programs, and advocacy for anti-drug-abuse health policies. The media can be used to shape public opinion, increase community readiness, educate the public on possible problem solutions, help recruit members for the advisory group, and solicit contributions. However, experience suggests that few community members will be solicited through advertisements for volunteers. Volunteers respond to more personal and direct contacts from the prevention organization.

Deciding on the Message

Media specialists in substance abuse prevention recommend that prevention messages should contain more than just the horrors of the problem; otherwise, feelings of hopelessness may be created. Therefore, public awareness campaigns should:

- Convey messages of hope;
- Alter negative perceptions of the persons at risk;
- Present the problem solutions in a positive light;
- Encourage volunteerism; and
- Build community and social support for action.

For additional tips on public awareness strategies, the reader is referred to *Persuasive Communication and Drug Abuse Prevention* (Donohew et al. 1991) and *Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk* (Arkin and Funkhouser 1990). The latter publication is available through NCADI (see appendix A).

Defining and Focusing the Message

The results of needs assessments provide a foundation for defining the nature of local substance abuse problems and targeting and accurately focusing messages intended to raise community awareness. In general, the broader the focus of community awareness efforts, in terms of both the public to be addressed and the substance abuse problems to be described, the less effective these efforts will be. Messages simply saying that "somebody, somewhere, has a problem" will not be heard and accepted in a media marketplace crowded with thousands of other messages.

A successful effort requires identifying the target audience, determining the appropriate message (one that will be noticed and believed), and identifying the correct media to deliver the message. In many cases, this will force a prioritization of communities or neighborhoods and problems to be addressed. Resources are rarely adequate to address every segment of the population, and approaches that are too broad are seldom effective.

Developing a Public Awareness Marketing Plan

Once a series of prevention messages has been developed and segments of the community to be targeted have been defined, a marketing plan can be developed. Marketing plans come in many varieties, but certain topics find their way into every plan. The following topics should be included in the public awareness marketing plan for a substance abuse prevention effort:

- Situation analysis (background of the problem or need);
- Goals and objectives;
- Strategy statements;
- Action steps;
- Budget; and
- Controls.

Situation Analysis

Situation analysis is a description of the current circumstances within the community that have prompted the members of the community to take action. In essence, the description is a definition of the problem or need based on the major findings of the community needs assessment.

Goals and Objectives

The situation analysis defines where the community stands at a specific point in time. The next step in the marketing planning effort is to develop a statement of where the community should go in addressing its identified problem. Goals define where the community should be, and the objectives define interim accomplishments along the way to accomplishing the goals.

Strategy Statements

These represent the broad outline of the means by which the goals and objectives of the community prevention effort will be achieved, including general approaches and underlying philosophy. Although these are not descriptions of specific action steps to be taken in implementing the prevention effort, they are descriptions of major areas or issues toward which the proposed prevention efforts should be directed. In the development of these strategy statements, prevention planners must enlist the input and cooperation of people who will carry some responsibility for helping the community achieve its prevention goals.

Action Steps

If the strategy statements are the broad outline for how a community proposes to achieve its prevention goals, the action steps are the specific prevention activities that will be taken to achieve the objectives. As specific activities are identified, so also are specific individuals and/or groups identified who will be responsible for ensuring that the activities occur.

Budget

The budget is a numerical description of the actual and/or anticipated costs associated with each activity to be undertaken in the prevention effort and should be developed to give consideration to anticipated as well as unanticipated program costs.

Controls

Finally, controls are procedures and activities designed to monitor the implementation of the marketing plan and evaluate the outcome of the marketing effort for the goal of substance abuse prevention.

Regardless of the size of the marketing budget available to local prevention providers, it will be minuscule in comparison with the marketing budgets of commercial advertisers. In many cases, local prevention providers will have no advertising budget at all, but a number of marketing campaign strategies can be employed, several of which can be used at the same time in a media blitz. These strategies include:

- Paid media time;
- Donated commercial time;
- Public radio and television;

- Newsworthy prevention activities; and
- Local community organizations.

Paid Media Time

Paid media efforts must be targeted carefully if they are to have any discernible effect. There may be a place for paid television messages, but production and air-time costs will usually make them prohibitive. The production costs for a short advertisement or community message can be as high as $70,000, depending on the complexity of the production. Less glamorous, but also less expensive, are radio, newspapers, billboards, bus cards, posters and flyers, T-shirts, calendars, and other means of getting prevention messages across. Most of these advertising outlets typically will allow communities to target their audience, for example, by age, ethnicity, or income, more precisely than television can and at a much lower cost. Similarly, community newspapers will offer much more frequent exposure than a general citywide newspaper and again allow the message to be more precisely targeted to the appropriate audience.

Donated Commercial Time

Donated time for public service announcements (PSAs) is available from both radio and television stations. The times for the PSAs are typically brief, and there is no control over when the messages will be aired or how frequently. This is particularly true of television stations where prime time carries a premium price. Nevertheless, this outlet should not be overlooked, particularly if an appropriate celebrity will act as spokesperson for the prevention effort or if the community can locate appropriate existing videos or film clips to air. The Partnership for a Drug-Free America has developed antidrug messages that can sometimes be used with permission granted by the Partnership in New York City (see Appendix A). In addition, NIDA has produced PSAs that are available through NCADI. When using PSAs developed by someone else, it is important to test them on the local population to ensure their effectiveness.

Public Radio and Television

The impact of educational media programming falls somewhere between paid broadcast air time and PSAs. The audience typically will be much smaller, but it also will be self-selected and especially attentive to the message. Clearly, many audiences will not be reached through this medium, but if station listenership corresponds to target groups, public broadcasting presents an extremely effective medium and at virtually no cost. Public broadcasting also effectively reaches community opinion leaders whose goodwill and active support may be essential to success.

Newsworthy Prevention Activities

By far the greatest return on effort will be obtained by learning how to make local prevention information and efforts newsworthy. Getting free news, talk show, or documentary coverage is the best television or radio coverage possible because it provides indepth coverage at no cost and is aired during desirable times. Local prevention services providers can establish a designated contact person or spokesperson who can answer questions from journalists. Establishing a track record for accuracy and responsiveness is absolutely essential. News outlets work on tight deadlines; therefore, the contact person always should ask when the material on the prevention activity is needed. The media contact person can learn to supply text, graphics and photos in the form required by the media. Having this kind of material ahead of time, that is, on file, will facilitate the effort to be responsive.

It is necessary to learn to anticipate when a prominent lead story will prompt local journalists to look for supplementary information. Meeting the needs of journalists can help increase access to the media. Having a speakers bureau to supply resource people to broadcast community affairs, public issues forums, and talk shows also can be effective. Members of the local communication advisory group can instruct prevention program staff in all aspects of media relations.

Local Community Organizations

Finally, communicating with the target populations through local community organizations is extremely important. Media efforts may best be understood as supporting or reinforcing the efforts of these local organizations. Most organizations will have regular meetings and publish newsletters, and program chairs and newsletter editors always are looking for material to put on their meeting agendas and to fill their newsletter pages. An offer to provide meeting speakers or newsletter stories, especially if carefully tuned to the interests of the organizations, will rarely be refused.

Addressing local groups will produce the greatest benefits when it is directed to people with an established interest and a stake in the community. These individuals will be an important resource in helping shape plans and garner the necessary community participation in prevention efforts. These organizations exist because their members want them to; therefore, association with them can give important credibility to the prevention efforts. In meeting presentations and newsletter articles, it is necessary to allow time to communicate the seriousness of the drug abuse problem, a sense of hope that the problem can be solved, and the need for broad community participation in solving it.

Implementing the Marketing Plan

The final steps in an effective media campaign are to implement the campaign and assess its effectiveness. If a community prevention organization has sufficient funds earmarked for community awareness efforts, it may choose to hire an advertising agency to help implement the marketing plan. An advertising agency can create logos, graphics for T-shirts, posters, billboards, and flyers as well as television spots. Occasionally, an advertising agency will work on a prevention campaign for low or no cost. Selection of the best agency for the particular needs of the community can be difficult, and the communications advisory group can be helpful; but some selection criteria may include similarity and quality of previous work of the agency, specific expertise in the area of prevention, and comprehensiveness of services. An evaluation will help the program organization determine ways to improve the campaign approaches used over time. Media specialists can help in this effort by designing an evaluation approach that can measure the impact of the public awareness efforts in changing opinions and behaviors. Some outcomes that can be measured include respondents' exposure to and recall of the ads, impact of the ads on telephone calls for help or to volunteer, and participation of community members in publicized community events.

Step 3. Access Community Resources

If a community is found deficient on the key readiness factor related to the existence of and access to adequate resources, there are specific strategies that can strengthen resources so that substance abuse prevention programming can be implemented successfully. The ability to marshal resources is a significant sign and an essential prerequisite for the continued vitality of a coalition. A coalition of prevention agencies can accomplish worthwhile objectives simply through periodic meetings of its members; but this limited level of cooperation is enhanced if the coalition is able to garner financial resources of its own. For example, the contributions of volunteers can be made significantly more productive if even modest funds are acquired for equipment and materials. The significant test of a vital coalition is not whether its individual members contribute funds to a single budget but whether the coalition can apply the funds and other resources to accomplish the coalition's objectives.

Raising Financial Support

Although financial and human resources are necessarily interrelated, the financial challenge to a coalition initially can be the most daunting. Financial support can be obtained either through the budgets of participating agencies or by asking directly for other public and private support.

Startup Resources

The successful launch of a coalition requires an initial commitment of resources, usually in the form of contributions of material and services from the initiating agencies and members. The most modest beginnings requires meeting and office space, duplicating and printing facilities, and limited staff support. As a practical matter, the work of creating a coalition is greatly enhanced if some time of agency staff is made available to commit to the coalition. These contributions, even of volunteer time to stuff envelopes, can be recorded because they form an important demonstration of the initiators' commitment when they present their case for new and external support. Many Federal grant applications require matching funds, which can be provided through in-kind contributions, such as the provision of office space, word processing support or duplication services.

The Role of Agency Funds

The most promising source of funds for the prevention effort is contributions from the participating organizations. Private funding sources generally provide seed money or startup funding to launch an effort; they rarely fund ongoing operations and cannot be depended on for continuous funding. Similarly, most government grants are designed to test new ideas or to provide startup funding, with the expectation that other funding support will be obtained to ensure the program's continuation. (The requirement for a plan to continue the program after funding ceases is often a condition of grant funding.) Whatever the source of initial funding, coalitions must plan for their continued funding. Participating agencies may agree to contribute a portion of their budgets (if their bylaws permit it).

Pursuing New Funding

The active pursuit of new sources of funding is a never-ending quest of community coalitions. To maintain their viability and grow, coalitions must establish funding as a priority activity. Therefore, strategies must be developed to address this significant need.

Create a Funding-Development Working Group

Volunteers from local development offices of hospitals, foundations, universities, and some private, nonprofit agencies are experts in raising money. Therefore, these experts can be tapped to participate on a funding- development working group of the coalition. These experts know local and national foundations and corporations, private donors, and ways to conduct fundraising events. Because their employers expect them to raise money for their own agencies, it is important to choose members for the coalition's funding-development working group who raise funds for nonprofit organizations that are not engaged in drug abuse prevention or social service activities, for example, a local symphony or arts group.

The charge of the funding-development working group might be to review the coalition's strategic plan and develop appropriate funding strategies to support the plan. A plan for long-range funding needs to be developed, particularly if any existing Federal or State funding for the coalition is short term. Beginning early, years before current funding ends, is essential to the longevity of the coalition and its overall efforts.

Potential Funding Sources

Many different potential sources for money, equipment and/or staff can be considered, including:

- Federal grants;
- State and/or local grants/contracts;
- Foundation and/or corporation grants; and
- Private donations and direct solicitation.

Federal Grants

Funds can sometimes be obtained by direct grant from Federal agencies supportive of substance abuse prevention activities. In addition, funds can be obtained through Federal grants to States or local governments, which allow for the release of matching State and local funding to support prevention activities. Most Federal grant funding for substance abuse prevention is earmarked for demonstration/evaluation projects or prevention research projects designed to stimulate the development and test the effectiveness of specific strategies or approaches with specific target populations. These Federal funding mechanisms require comprehensive evaluations and data collection mechanisms designed to determine the effectiveness of the funded projects. In other words, these grants are not intended to be used for service delivery. Service delivery grants are available through State and/or county funding mechanisms. Some funding is available for training or conferences through the Federal Center for Substance Abuse Prevention. A list of potential Federal funding agencies is included in appendix A.

State and/or Local Grants/Contracts

State, county, and local (city, township) budget appropriations can be pursued for service grants in prevention. State and county agencies typically have little new funding because most of their funding from Federal or State sources is already allocated to existing prevention service providers. However, occasionally new coalitions may be given a

chance to compete directly for community development block grants. These are funds provided in lump sums (blocks) by the Federal government to State and municipal governments; they are awarded for community development projects at the discretion of the recipient governmental entity. (Current congressional plans call for directing more money to State block grants and less to Federal programs, so block grants may prove to be a better source of funding for prevention activities in the future.) Sometimes, State and county agencies have unspent funds at the end of a year that they may be willing to allocate to a community coalition for short-term projects. Maintaining communication with these agencies will help increase the possibility of obtaining such funding.

Foundation and/or Corporation Grants

A lot of time may be saved by engaging the skills of a professional fundraiser as a volunteer or paid consultant in approaching local corporations and foundations. However, an interested staff member or volunteer with writing skills can master the essentials of grant writing. With the exception of grants from major national foundations that have specific programmatic interests and whose grants are fiercely competitive, foundations, like corporations, tend to give to their own local communities. Therefore, local foundations and locally owned corporations also may be helpful sources for funding.

Foundations and corporations prefer letters requesting funding, which succinctly outline the goals, objectives, program strategies, and populations to be served by the program. This information should be supported by a summary of the proposed program budget and an indication of other sources of program support. Although foundations and corporations will look for some evidence that the proposed program will be evaluated, they will be more interested in assurance that the activities, if successful, will be adopted and maintained by the local community. They do not usually require the elaborate, technical research and evaluation plans needed to secure Federal research grants.

When approaching corporations, it is important to remember that recognition and good publicity with their target markets is extremely important to them. Therefore, the coalition leaders should consider who these target audiences are and how the coalition can offer the corporate donors favorable publicity with them. However, these opportunities for publicity must not be oversold. Corporations may prefer to make in-kind contributions to the prevention efforts in the form of products, meeting or office space, or services such as printing that can be done during company off-time.

Private Donations and Direct Solicitation

Some community organizations exist primarily on private donations and direct solicitations (requests for donations) for funding. Being listed as a United Way agency is one way of receiving funding. When private funding is pursued, reallocation of existing coalition member agency resources demonstrates a commitment to the mission and goals of the coalition. It says "Look what we have done with what we have." This approach can be quite persuasive when the coalition is seeking funding from private sources.

Building Momentum

Coalition members should remember the recurring need to make their case and document their commitment in the pursuit of additional funding from both public and private sources. For public sources, the case usually should be made by agency heads, but coalition members need to supply the necessary supporting materials and may, in some cases, participate in public budget hearings. Coalition commitment to long-term and productive relationships with mayors, council members, commissioners, governors, and State or local legislators is as important as this year's budget.

Given the tendency of funding organizations to ask, "Who else is backing you?," the initial allocation of coalition resources becomes a powerful demonstration of commitment with which to approach private funding sources. Success with private sources also can be used to demonstrate public concern. Resources already committed set the effort apart from the much larger number of good ideas looking for a start. However modest, these resources are an important element of the case for additional support. Finally, breadth of support is another important factor in making the case for additional funding from government and especially from foundations and corporations. A broad base of support from seriously committed community organizations and agencies is an important asset.

Step 4. Develop a Strategic Plan

When a community has a variety of substance abuse prevention programs and activities operating but no clear idea how these various efforts are related or coordinated, the community is deficient in its readiness to implement prevention programming because it lacks a coherent vision or a plan. Therefore, the community can improve this readiness factor by initiating a process to develop a strategic plan. A strategic plan is a document that outlines not only the community's vision for drug abuse prevention but the strategies for making that vision a reality. In effect, it is a roadmap that provides guidance to the community in its efforts to implement effective programming. A strategic plan requires that a community develop, at least, the following:

- A theory about the problem, that is, developing an understanding of the psychological and social factors affecting the problem and the interrelationships among the risk and protective factors associated with the problem;

- A theory about which prevention approach to take, that is, community members becoming knowledgeable about previous approaches to the problem and the relative effectiveness of these approaches with different cultural groups and target populations; and

- An awareness of the program context, that is, community members becoming aware of the organizational, community, and cultural situations in which the prevention program will operate.

An effective strategic planning approach to substance abuse prevention requires consideration of the degree of match between proposed prevention programs and important factors operating within the community. These community factors, including community norms, attitudes, and values; a sense of community or belonging among community residents; a willingness to act through collaborative efforts; the level of commitment; and a host of other factors, all affect community readiness. A prevention approach that simply provides services to meet community needs can actually intensify the problem by focusing on service provision rather than on strengthening the capacity of a community to solve its own problems (McLeroy et al. 1993). For example, providing additional youth services staff to work with troubled youth rather than increasing the capacity of parents to improve the behavior of their children misses an important opportunity for parental growth and increased parental effectiveness. Therefore, prevention services should not become a substitute for increasing the local community's capacity to handle its own problems.

A strategic planning approach can take different forms and involve a variety of activities. For example, one strategic planning approach is a 12-step planning model for substance abuse coalitions, part of the Strengthening Communities Program (Kumpfer et al. 1991). Another strategic planning process is reflected in the Planning Guide provided in appendix C. Regardless of the particular strategic planning model adopted by a community, the planning process should incorporate the following activities:

- Identification of who will develop the strategic plan through the formation of a strategic planning team and task forces to work on specific aspects of the plan;

- Development of a common base of knowledge among the planning team members;

- Assignment of responsibility to the planning team members and task forces; and
- Development of the written plan.

Identification of Who Will Develop the Strategic Plan

The development of a strategic plan for a community will be a massive and complex undertaking, involving diverse segments of the community. Therefore, a first step in the strategic planning process should be the establishment of a strategic planning team whose responsibility it will be to develop a plan for addressing local prevention needs. In addition, it is often wise to designate task teams to work on specific aspects of the strategic plan, such as resources, organizational structure, and public awareness.

The formation of task teams can be accomplished in several ways. Based on information provided by the people who attend the first organizing meeting of the coalition (see Step 7), the areas of interest and expertise of the coalition members can be used as the basis for their assignment to particular teams. Some teams, for example, can be established on the basis of the characteristics of the populations that are targeted for prevention, such as school-aged youth, college students, business employees, senior citizens, ethnic minorities, and families at risk. Specific planning efforts are thereby focused on each defined target population and then integrated into a total community strategic plan. This strategy works well in geographically large communities, that is, cities or other major metropolitan jurisdictions. An alternative approach is to establish task teams on the basis of small geographic neighborhoods and then combine the plans into a comprehensive plan for the community. This strategy would be appropriate for smaller communities and towns.

The work of the task teams can be either short or long term or both depending on the particular issue their planning efforts are designed to address. For example, a task team may be established for a short time to address a particular issue such as resources. However, it may later develop that this issue is of such magnitude and importance to the coalition that it will require the team's involvement over a longer time. Thus, the short-term planning team takes on a long-term effort. On the other hand, a planning team initially may be established to address a long-term issue such as public awareness of substance abuse and its prevention. It will be the responsibility of the leadership body of the coalition (see Step 7) to coordinate the planning work and the results of each task team's efforts.

Some task teams may be established to plan prevention strategies for selected risk factors, such as antisocial peer influence or family dysfunction. Other planning approaches might involve teams working on issues relevant to particular subgroups, such as drug abuse and pregnancy, drug-free schools, or driving under the influence of alcohol and drugs. Regardless of the particular basis for the establishment of the task teams, the individuals recruited to work on each

team should, to the extent possible, be representative of agencies, associations, and citizens groups that have an expressed interest or stake in the issues of the target populations of the planning efforts.

Development of a Common Base of Knowledge

An important consideration in any strategic planning process is determining the level of knowledge and experience of those who will constitute the strategic planning team. If the coalition is composed entirely or predominantly of prevention providers but with broad participation from the community at large, then strategic planning can proceed quickly, drawing on members' shared professional knowledge and skills in substance abuse and its prevention. However, if nonprofessional community members or professionals from outside of the prevention arena play a prominent role in the planning process, then the process will likely proceed more slowly, requiring essential time devoted to educating the planners about substance abuse prevention. Any coalition that expects to obtain support from nonprofessional members of the broader community will need to ensure that their participation is not taken for granted and that meeting discussions are not weighed down with the use of professional jargon or other terms that are unfamiliar to these members and tend to exclude or ignore their needs. Even if the plan is developed solely by professionals who are from different segments of the community, they too will need to develop a common base of knowledge in prevention.

Educating the Planners

It is desirable to have an organized effort to educate planning team members in the planning process, that is, in how to plan. Different planning models can be used, and many exist. However, the principle idea is that the planners be instructed in the specific planning process the organization will use and what the final product, that is, the plan, will look like.

Whether professional or lay members dominate the planning team or whether there is a balance among the types of members, strategic planning will require the same basic steps. The planning teams must:

- Determine what aspects of substance abuse are most pressing within the community;
- Determine the goals and objectives of the prevention effort; and
- Choose prevention approaches that are likely to succeed and possible to implement with the available resources.

Introducing Planners to What Works in Prevention

Planners should select prevention approaches that have demonstrated effectiveness; but to do that, they need to be exposed to the range of successful and promising prevention strategies. The goal of such exposure is to develop a common base of knowledge so that all members of the strategic planning team end up speaking the same language of prevention. Some planning team members already may have ideas about what the prevention approach should be, and unique or new solutions to substance abuse should be respected and considered. However, to avoid premature closure on any particular approach, the planning team should be exposed to many different successful prevention strategies. This can be accomplished through a variety of mechanisms, including:

- A kick-off conference, including a training course on prevention ("Prevention 101") and workshops describing local prevention programs;
- Attendance at State or national conferences that showcase strategies and approaches that work in substance abuse prevention. Lists of such conferences can be obtained from some of the agencies identified in appendix A;
- Visits to local or national prevention programs to observe their operations;
- Discussion groups and presentations by planning team members on completed assignments to locate promising prevention programs;
- Review of relevant research studies on effective prevention programs gathered from city or university libraries and by conducting literature searches; and
- Discussions with prevention specialists in the area.

The handbook contained in this RDA package, *Drug Abuse Prevention: What Works*, can serve as a guide for planners to learn about effective research-based prevention strategies. It will be important to present as wide a range of alternatives as possible and to avoid prematurely narrowing the range of potential program options.

Assignment of Responsibility

At this point in the planning process, the planning team will begin the work of creating a written plan to increase the community's capacity or readiness to implement drug abuse prevention programs. It is at this point that the coalition, through its governing body, will give the planning team its charge, that is, a specific direction with regard to what its task will entail and the products or results it is expected to produce. The principal reason for team members'

collaborative efforts should not be to have endless planning meetings, but to support capacity building, that is, to plan ways to support the community to implement effective, research-based substance abuse prevention programs and services that will address the local problems and needs.

Short-Term Planning Teams

Short-term planning teams may be established at any time throughout the life of a coalition, but they are especially important during the formative months of the coalition. Such short-term planning teams are established for specific goals, the results of which may be generally applicable to the entire coalition. For example, they may be established to identify problems, plan courses of action, identify and access resources, or evaluate a coalition activity. Members of short-term planning teams should understand that the life of their particular team is short, perhaps only a few weeks or a few months. The outcome of their work will be preliminary reports or recommendations to the coalition council (see step 7 for a full discussion of coalition subunits). If the recommendations of these short-term planning teams are adopted for implementation, the members may, but need not, continue with that project. Planning teams can be prepared to report their best assessment of the problem in their community, points and strategies for effective action, and resources required and available for relevant action.

Long-Term Planning and Implementation Teams

These teams are charged with the responsibility for making the strategic plan a reality, or implementing it. Their work may include attracting the necessary funding (e.g., applying for coalition funding, using committed agency funding, or attracting outside resources and funds) to implement the proposed prevention strategies. If this approach is followed, the coalition structure must be organized to support these efforts. This is an exciting and invigorating element in the planning process. Knowledge that what they plan can really happen increases the team members' commitment and enthusiasm for the difficult planning process. However, knowing that they are responsible for implementing or attracting staff to implement their prevention plan will infuse an important element of reality into their plans.

Defining Planning Activities

The long-term planning teams may address a range of prevention activities, such as community education and public awareness campaigns; school-based skills development, parenting education and skills development, and family communication skills development programs; and employee assistance programs. However, the choice of the specific activities to be implemented should be based on the coalition council's assessment of political feasibility, from the perspective of both prevention provider agencies and the broader community. Drawing on the reports and recommendations of the short-term planning teams, council members should agree on the priority of the problems to be addressed by the coalition and how responsibility for the work is to be

shared among the various segments of the coalition. Council members face a difficult task in this decision, recognizing the interrelatedness of many substance abuse problems and the planning teams assigned to address them. The prevention strategies must be as comprehensive as possible yet focused enough to avoid the risk of dissipating resources and having little measurable impact on the community.

Activities of the Planning Team

When the planning team begins its work, it should start with an statement of the goals of its work, that is, the changes in substance use and abuse behavior it hopes to achieve. From this point, the team can then work backward to identify prevention approaches that are both appropriate to the identified community needs, risk, and protective factors and affordable with the community's resources. Team members can begin by asking, "If we are successful in our efforts, what will be different in our community, and how will we know?" Team members need to understand each other's concerns and support each other to find research-based strategies that respond to those concerns. Team members also must be able to identify and avoid planning strategies that have little chance for success in their community or which even have been demonstrated to have negative effects so that the coalition will avoid wasting valuable resources on losing propositions.

The planning team may need to have a modest budget to allow it access to appropriate literature on subjects of relevance to its work and to draw on the experience of other agencies and coalitions. Telephone calls and visits to programs are an important resource for the planning team to avoid pitfalls identified from the experiences of others. Direct observation can give inexperienced planning team members a more concrete appreciation of what a given prevention approach may mean in practice.

Development of the Written Plan

The strategic planning process can result in a formal written document that presents in specific detail the plan that will guide the implementation of the communitywide substance abuse prevention effort. An outline for the strategic planning document can be developed and provided to each planning group. The outline will help focus the work of the planning team on the specific issues to be addressed during the planning process and serve as an organizing framework for a strategic planning document. A planning guide is provided in appendix C. The strategic plan should address, at a minimum, the following issues:

- *The problem*: a statement of the problem or problems to be addressed by the planning team. This statement should be based on the findings from the community needs assessment previously discussed;

- *Goals and objectives*: a discussion of the desired change in behavior, including long-term goals as well as immediate and shorter term outcomes of the proposed prevention effort;

- *Prevention strategies*: a description of the specific prevention activities chosen for implementation and a summary of the reasons for their selection; and

- *Resources*: a list of all the resources that are expected to be required to implement the prevention approach, including the necessary staff, facilities, equipment,and other resources. This point was discussed previously in step 3.

Using a Logic Model

Logic models are one-page graphic summaries of the essential elements of strategic plans. They can be used in any kind of strategic planning process where it is important to determine whether the proposed activities are logically related to the expected results of the program. Logic models depict visually the assumptions underlying the program's structure, that is, assumptions about which strategies will be most effective in achieving the objectives and what resources are needed to implement the strategies effectively. Specifically, logic models specify:

- All the resources that will be needed for the effort;

- The specific prevention program/activities that will be implemented;

- The anticipated immediate or short-term effects (objectives) of the activities; and

- The anticipated long-term outcomes or goals achieved by the participants in the effort.

Logic models can help focus the planning process and ensure consensus among the planners and groups that have a vested interest in the prevention effort; everyone needs to agree on the goals and objectives of the project and the strategies that will be implemented to achieve them. Logic models also are required by some funding agencies and often are used in Federal evaluations of programs. To learn more about how to create a logic model, see *Measurements in Prevention* (Kumpfer and Hopkins 1993) or contact the Center for Substance Abuse Prevention (see appendix A).

Criteria for Selection of Prevention Programs

There are perhaps as many prevention programs as there are communities wishing to implement them, and a community may have a difficult time determining which programs will be appropriate for its particular circumstances. To provide some guidance in the selection of appropriate prevention programs and/or activities, communities should apply the following three major criteria in determining which prevention strategies to develop:

- *Technical/scientific criteria*: determining whether planning team members have a good grasp of why the problem is occurring (have a theory of the problem) and whether team members have a theory of the prevention approach (a research-based justification for why the particular prevention approach was selected to address the identified problem);

- *Political criteria*: determining whether the selected prevention approach will be accepted in the community and whether local citizens will give enough support to the prevention approach for it to have a chance of success; and

- *Cost criteria*: determining how costly a particular prevention approach will be in relation to the size of the expected benefits and whether the community has the necessary fiscal and staff resources to implement a particular approach.

In addition, the planning team should determine the level of knowledge of its members about the variety of factors, such as intrapersonal, interpersonal, organizational, community, cultural, and public policy factors associated with substance abuse and by extension its prevention. Knowledge of these kinds of issues will provide a framework within which planning team members can assemble and summarize all the information they have learned about:

- The causes of the problem from the needs assessments and literature reviews that will help them to create a theory of the problem;

- The theory of the prevention approach to be used based on research findings of what works in substance abuse prevention; and

- The community's readiness for program adoption and potential places to intervene with cost-effective prevention approaches (McLeroy et al. 1993).

Reconciling Individual Plans

In considering the implementation within the community of the plans developed by each planning team, the coalition council will be concerned primarily with determining where there is interface between the plans, that is, determining how the work of one task team will affect and be affected by the work of other teams. Questions of practical interface will necessarily arise and will need to be carefully considered by the coalition. For example, if one team's plan calls for afterschool activities in the school and another team's plan calls for afterschool activities in the home, how can these separate activities be coordinated? How can different aspects of a strategic plan be reconciled?

Resource allocation will pose a particularly thorny challenge for the coalition. Limited resources, such as money, space, and volunteer time, will necessarily require careful planning. Decisions must be made about which program activities to pursue and which to defer until further resources become available. Therefore, the coalition's strategic plan can include recommendations about program priorities to guide resource allocation decisions. Program implementation timelines that are based on budget considerations that include the specific activities, their costs, and expected sources of funding will help facilitate the resource allocation process.

Council members should not ignore the desirability of achieving some early successes from the coalition's efforts, even if they are modest, to provide a sense of positive movement and reinforce the cooperation and political support of coalition members. Therefore, prevention activities that have a good chance of showing early positive effects may be given higher priority for implementation than activities that will take a long time to show positive results. Council members also should remember the importance of continuing to acknowledge coalition achievements that can be documented and celebrated at public events.

Writing for Community Acceptance

Finally, it is recommended that the strategic plan be written in language that is appropriate for the coalition, planning agency, or funding sources. Technical appendixes that provide great specificity and detail can be included. If the plan is for general community review, the finished product will be an essential tool for rallying support and commitment in the wider community. It is important in this case that the plan speak clearly to the community's hopes and fears on the emotionally charged matter of substance abuse. A strategic plan that is unintelligible to its readers will fail in its objective of rallying community support.

Step 5. Maintain Momentum

If the degree of readiness of a community to mobilize and sustain the prevention activities is found to be deficient, the following discussion presents strategies by which this key readiness factor can be strengthened. Community organizations are frequently less successful at sustaining the momentum of the organization after the more glitzy and exciting mobilization phase of the prevention effort (see Step 6). Therefore, mechanisms will need to be created for the coalition

MAINTAINING COALITION MOMENTUM

- Develop formal rules, roles, and procedures
- Retain professional staff
- Retain nonprofessional community members
- Retain reluctant members
- Offer various ways to participate
- Increase benefits and reduce costs associated with membership
- Decrease barriers to participation
- Increase sense of role importance among members
- Identify and resolve agency and personal conflicts
- Continually recruit, orient, and train new members
- Prepare new leaders-in-waiting
- Identify and raise funds
- Remember that things take time
- Build a resource databank

to maintain the momentum of the prevention effort. The activities listed in the chart below have been found to be important mechanisms for maintaining the necessary momentum of the organization. However, a significant aspect of maintaining the momentum of a coalition has to do with the retention of coalition members—professional, nonprofessional, and reluctant members—and with increasing the benefits and reducing the costs associated with coalition membership.

Rules, Roles, and Procedures

A formal structure that includes an organization chart with clearly specified roles and responsibilities and organizational operating procedures is an invaluable tool. Not only does it add to the credibility of the organization when approaching potential funding agencies or others; it also helps establish the structure that staff (including volunteers) need to feel comfortable and to understand the contribution their work makes to the total effort. The formal structures can include:

- Job descriptions, defining specific duties and performance standards;
- Job classifications and salary scales that delineate career paths in the organization and establish an objective base for making salary determinations;
- A formal bookkeeping and recordkeeping system;
- Policies and forms for reimbursement (e.g., for travel expenses);
- Policies and procedures for handling a variety of situations, including for example inquiries from the press.

Depending on the nature of the organizational structure, it may be necessary to establish formal bylaws to govern such things as the selection of board members and policies for hiring the executive director.

Coalition Member Retention

The requirements for retention in the coalition differ for professional and nonprofessional members, and each is discussed separately below.

Professionals

The active participation of professionals is important for prevention activity success. If their personal needs are not reasonably met, they are likely to abandon active, contributing participation. For example, in the case of prevention professionals who are employed by member agencies and organizations, it is desirable to obtain their formal assignment to work with the coalition, perhaps incorporating the new prevention activities into their current job descriptions.

Failure to obtain these redefinitions of work responsibilities runs the risk that coalition membership will be seen as something extra, the first task to be ignored if time pressures build within their "real" jobs.

Nonprofessionals

In some cases implementing a prevention effort may not be as difficult as maintaining the interest of nonprofessional community volunteers over time (Prestby and Wandersman 1985). The rewards for community members often are intangible or at least not immediate. Participation must feel productive in achieving the members' objectives within the community at large, within the organization they represent, as well as personally. Community prevention organizations often have a difficult time maintaining the participation of community volunteers once the initial enthusiasm has worn off (Miller et al. 1979). Dropout rates as high as 50 percent have been reported after initial mobilization activities have been completed (Yates 1973).

It is critical to identify factors that contribute to member satisfaction with and participation in the coalition. Interviews can be conducted with identified leaders within the coalition to gather data about what they do to enhance member participation. For example, Prestby and colleagues (Prestby et al. 1990) found that active members in block associations identified higher personal benefits and lower costs of participation as important factors in their remaining active in the organization.

Reluctant Members

All groups shift toward a more homogeneous membership as the dominant group gives the organization its imprint. Therefore, coalition members who are not part of the dominant group may feel left out. In the worse cases, these members may feel discriminated against or harassed and may drift away from the coalition. Therefore. a conscious effort must be made to recognize and value less influential groups and individuals to retain their membership and support. In addition, recruitment will be easier by working through groups whose purposes suggest interests parallel to those of the coalition.

Types of Participation

Although participation in community coalitions is frequently treated as an all-or-nothing situation, there are different ways in which members can be encouraged to participate. Research has shown that there are different levels or types of participation that members of community coalitions exhibit (Wandersman 1981). For example, participants can:

- Assume positions of leadership where they have power to make decisions;

- Participate on planning teams to influence decisions about the prevention approaches selected;
- Serve on advisory boards to provide opinions about the choices of prevention approaches to match community needs;
- Serve as staff members or volunteers in implementing the programs; or
- Choose to not participate.

Therefore, when members are being recruited for planning teams for prevention programs, they should be told that they can participate in different way and at different levels of time commitment, depending on their availability. Matching the members' time and interests to specific coalition activities will counteract burnout and ensure continuing participation.

Benefits and Costs of Participation

Recruitment and retention of members to participate in the coalition will depend on increasing perceived benefits of collaboration and decreasing costs of participation. According to Butterfoss and colleagues (Butterfoss et al. 1993), Benard (1989), and Wandersman and Alderman (1993), potential *benefits* of participation in community coalitions include:

- Increased networking and friendships;
- Information sharing and access to resources;
- Contribution to solving an important community problem;
- Enjoyment of the work of the coalition;
- Personal recognition for talents and efforts; and
- Increased personal skills and knowledge.

Potential *costs* of participation can include:

- Time devoted to coalition activities reduces time for family, job, and other obligations;
- Loss of autonomy resulting from collaborative decisionmaking;

- Perceived lack of leadership within the coalition;
- A feeling that talents are not being utilized;
- Lack of skills to do certain tasks; and
- Lack of appreciation or recognition for work accomplished.

Coalitions must find ways to increase the benefits and decrease the costs of member involvement. A favorable cost-benefit ratio increases the level of members' commitment and participation (Howard-Pitney and Rogers 1992). To improve the cost-benefit ratio, leaders can increase the benefits of membership by increasing information, skills, recognition, friends, networks, satisfaction, and recognition for a job well done. Therefore, organizers of prevention coalitions will have more active community members if they:

- Provide social incentives, such as ensuring that meetings are informational, motivational, and social and that people feel welcome at meetings where leaders stress community responsibility; and
- Reduce personal costs of participation by providing safe transportation and child care and keeping meetings convenient, brief, and not excessively frequent.

In some cases, the importance of providing incentives and benefits is greater than the need to reduce personal costs for members to maintain active participation because many community volunteers consider that the important goals of the organization outweigh many personal inconveniences (Prestby et al. 1990). Training and opportunities to meet people with similar interests provide additional rewards for volunteers. However, volunteers who may be eager to make a difference will eventually move on if the coalition seems to be achieving little. It is important to create the appearance as well as the substance of an effective organization.

Coalition and committee meetings should convene and adjourn promptly and on schedule. Copies of meeting agendas and supporting materials can be distributed to members in advance to allow for their review before the meetings but not so early that they are misplaced. Reminder calls or postcards sent to members before meetings will improve turnout and convey the message that members' participation is important. If members have been inactive, they can be asked whether a particular coalition task or activity would help to reengage them in the work of the coalition. If a member's departure is unavoidable, a handshake, a pat on the back, and a word of thanks are always appropriate and appreciated. An exit interview or discussion with the departing member can be a useful means for getting feedback, both positive and negative, about the things about the coalition and its activities that were important to the member that may be related to the reasons the member is leaving.

Other Strategies

There are specific factors that are important to the maintenance of active participation by members in the coalition. Although there are both costs and benefits associated with participation in the coalition, substance abuse problems are not new nor are the social problems in which they are rooted. Therefore, an understanding that change will take time and that coalitions require resilience and perseverance for change to occur is important. It is essential that close attention be given to the morale of coalition members and where possible efforts should be made to increase the benefits to be derived from coalition participation for both professional and nonprofessional members. Particular attention should be given to:

- Decreasing barriers to participation;
- Building planning team efficacy; and
- Increasing role importance and sense of empowerment.

Barriers to Participation

There are circumstances and factors that pose barriers to members' active participation in coalitions. These barriers include such things as inconvenient meeting times, lack of transportation for members, lack of perceived or actual safety of meeting locations, and lack of resources for child care. These kinds of barriers can substantially reduce the motivation to be involved in the coalition's drug prevention efforts. These barriers can be anticipated and addressed early in the formation of the prevention effort. For example, plans for carpools and child care can be developed as part of the planning for the first coalition organizing meeting. Meals can be provided during lunch and dinner time meetings to retain coalition members' active participation. In addition, scheduled times for coalition meetings may need to be changed to accommodate members' work schedules and fears members may have about being out after dark.

The physical safety of prevention organizers is important to the success of any prevention program. The environmental features of the community and the meeting locations can be analyzed for security, including physical barriers to unwanted entry, such as walls, fences, or security bars or entry points (Perkins et al. 1990). In addition, there are issues of territoriality (Altman 1975), or in whose territory the meeting will to be held. Some residents will not attend a prevention planning meeting that is held in a neighborhood, public housing community, or school that is different from their own. In addition, participants may be unwilling to attend meetings if they have to pass groups of youth who are unknown to them, prostitutes, or drug dealers loitering at the building entrance or nearby. These circumstances may increase the members' fears of assault (Perkins et al. 1989).

Team Efficacy

Research suggests that participants in community coalitions are more likely to remain active if they perceive that their efforts are effective, that is, if there is a sense of efficacy among the members (Butterfoss et al. 1993). Expectations of effectiveness in solving community problems increases participation and team satisfaction. According to Zimmerman and Rappaport (1988), a sense of efficacy also increases if participants are successful in organizing people, identifying resources, and developing strategies for achieving goals. Teams also are more satisfied if they have leaders who encourage and support members' ideas and planning efforts, use democratic decisionmaking processes, and encourage networking and sharing.

Role Importance and Sense of Empowerment

Feelings of empowerment lead to increased retention. Empowerment is developed on the basis of experiences within the group. The leader influences these experiences by encouraging positive social relationships and networking, providing encouragement of group members and opportunities for involvement in positive ways, and rewarding members' contributions and participation (Chavis and Wandersman 1990). Research suggests that a sense of personal efficacy would not be sustained long in a negative group situation (Kumpfer et al. 1993). If a group member is treated like an outsider, with little support or reward for participation and contribution of ideas or volunteer efforts, then his or her sense of self-efficacy decreases. Often the group leader sets the tone to make volunteers feel their contributions are as valued as those of the participating professionals.

Step 6. Mobilize the Community

The following discussion provides some strategies for increasing support from stakeholders, if the coalition is deficient in that area. The work of building a community coalition to implement substance abuse prevention programs does not end with creation of the formal organizational structure (see Step 7). Implementation or program development must be considered an ongoing task if the prevention effort is to survive and be effective.

Coalitions are fragile. A majority of members must feel that the returns to their community, their organizations, and themselves warrant the continued commitment of their time and effort. Changes in personal circumstances or disenchantment with some aspect of coalition activity will cause some attrition. New participants continually must be enlisted to take the place of those who leave. Continuing recruitment also will provide an opportunity to ensure the representative character of the coalition.

Coalition Member Recruitment

Whom to Target

Coalition members can come from prevention agencies or from the general population of the community. Member recruitment for a large coalition, composed mostly of volunteer members, can be a full-time job. Knowing who is likely to volunteer and remain active helps to target solicitation efforts. Research (Prestby et al. 1990) has shown that active members in community coalitions:

- Have a strong sense of community;
- Are likely to be homeowners;
- Have lived in their neighborhoods for some time; and
- Plan to stay at their current address.

Experience has shown that women who are not employed outside the home tend to have more time to be active in their block associations or community councils. Research also has shown that members of active coalitions perceive their organizations as cohesive, task oriented, and organized, and their coalition leaders as democratic, visible, and in control, yet supportive (Moos et al. 1974).

Recommended Recruitment Strategies

The best strategy for recruiting new coalition members is through direct invitations from friends. Coalition members can make a semiannual commitment to invite at least two other friends to join the coalition. Other recruitment strategies that have been used involve media campaigns with call-in telephone numbers for volunteers, letters to neighborhood residents, and requests for volunteers at coalition events, conferences, or training seminars.

Recruiting From Reluctant Constituencies

For a variety of reasons, members of ethnic minorities and lower income groups, young people, and older people frequently are underrepresented on coalitions. Nevertheless, each of these groups has a direct investment in the work of the coalition and important insights to contribute. The business of committees, agendas, and reports may be foreign to their experience and their interests as well. Remedying the absence of these groups is time consuming, and their membership is not assured. However, their involvement will produce important dividends to the coalition because their representation will help ensure the relevance of the programs to the whole

community. They may be recruited through groups to which they already belong. Such groups provide an already-assembled audience and a channel of communication and improve the chances of recruiting several members from the same group, helping to overcome reluctance to join a group with whom they feel little in common. A concerted effort to identify and remove barriers to participation will be worthwhile. Transportation and the choice of a secure, accessible meeting site may be problems for members of these groups and need to be given careful attention as part of the recruitment process.

Coalition Member Training

Coalition members will value their participation and consider their time well spent if they feel they have made, or can make an effective contribution. Training will improve the likelihood of effective participation and will be seen by many participants as a reward in its own right. Every member's participation can begin with an orientation to the concept and local history of the coalition. Its mission, goals, structure, and membership can be described succinctly in a member handbook prepared for training purposes and should be reinforced in a short orientation program. Such a program can be repeated at regular intervals or whenever there are a sufficient number of new participants.

A process for training new members and helping integrate them effectively into existing teams also is necessary. It may be sufficient to assign each new member to a buddy, someone who has been with the organization long enough to know the rules, for support and encouragement. The senior member may take the responsibility for contacting the new member if he or she misses several meetings or take the initiative in solving transportation or other problems. Ongoing training sessions for all members of a working committee will provide an opportunity for new members to participate on an even footing.

Coalition Member Involvement

Successful involvement of coalition members almost always will depend on engaging them in tasks where their skills can be used effectively. Conduct an inventory of members' professional and nonprofessional skills and interests. A comprehensive checklist is usually the most effective way to obtain this information; and it can anticipate all the activities the coalition will undertake and the skills those activities will require. The resulting information can be compiled into a skills bank for use in organizing activities and events.

A means for reaching all coalition members will be important. For some coalition events, a telephone tree will be suitable. In a telephone tree, members routinely call several other members who, in turn, call several other members until all members are reached. Older volunteers may find a calling list enjoyable. Distinctive postcards are highly effective with a wide range of volunteers. A newsletter can be useful in keeping all members informed of the activities

of the coalition. The newsletter need not be long or elaborate, but the information in it should be accurate, substantial, and current. If the coalition has received outside recognition for its efforts, a newsletter is a good way to ensure that everyone knows.

Coalition Events

Coalition events typically serve the purposes of educating and motivating both inside and outside the coalition. Internally, events provide opportunities to share information in a relaxed setting, to allow members to become better acquainted with each other, and to recognize and celebrate both group and individual achievements. The events can provide an opportunity to invite nonmembers whose future participation or goodwill and support are desired. The most visible and public events will attract the interest of local print and broadcast media and provide an opportunity for favorable publicity. Recognition of achievements at even social events will effectively remind both members and nonmembers of the serious purposes of the coalition.

The mechanics of event planning may be familiar to some members of the coalition who may be willing to staff a core working group responsible for events. Given a suitable checklist, even an inexperienced member can perform these functions. Planning for coalition events should start with a clear understanding of the goals of the event and how they will be achieved. All other decisions can be tested against those goals. Simply producing an event is not an objective in itself. The type of event, its location, sponsorship, guests to be invited, and support (e.g., cash and in-kind donations, activities, music, food, and setup and cleanup) will all fall more easily into place if the goals are clear at the outset. Event organizers should avoid the pitfall of trying to perform all the subtasks themselves because they will run the risk of burnout. Their job can be to recruit community participation, including enlisting the help they need to obtain that participation.

Step 7. Choose an Organizational Structure

Effective drug abuse prevention requires a community effort. Professional efforts without community support can have little lasting effect. This resource manual has previously addressed the benefits of community involvement in assessing needs for substance abuse prevention and suggested the value of treating the community survey as a means of increasing community awareness of substance abuse problems and for preparing the community to participate actively in solving them. An important step in the community prevention effort is the selection of an organizational structure and leadership that will enhance the probability of the success of the prevention effort. Social and health services professionals often miss the importance of this phase, tending to focus more on the need for services to be delivered.

Determining the Type of Organizational Structure

There are many different types of organizational structures that have been used to implement substance abuse prevention efforts. In general, the structure and leadership of a prevention effort is determined primarily by the sponsoring organizations (Robert Wood Johnson Foundation Fighting Back Survey 1989), but other determinants include:

- Membership and leadership;
- Target population;
- Funding source requirements;
- Size of budget;
- Activities that funding can be spent on; and
- Readiness of volunteers to participate.

The various types of community prevention organizational structures fall into the four major categories described below (Wandersman and Florin 1990). This resource manual and the rest of this discussion focus on only one type of organizational structure—communitywide coalitions.

ORGANIZATIONAL STRUCTURES

- Volunteer neighborhood organizations (e.g., block associations, neighborhood councils, church groups, local merchant associations, and youth clubs);

- Human services coordinating structures (e.g., community partnerships, community coalitions, or interagency coordinating councils that comprise service delivery organizations and target substance abuse);

- Communitywide coalitions that comprise representatives of organizations from multiple sectors of the community (e.g., volunteer service agencies, government, business, religious institutions, schools); and

- Self-help or mutual aid groups (e.g., 12-step programs for substance abuse, such as Alcoholics Anonymous, Al-Anon for spouses and significant others of alcoholics, and Al-Ateen for children of alcoholics).

Definition of Coalition Subunits

Within community coalitions often there are subunits, sometimes called committees, subcommittees, teams, or task forces, that are needed to share responsibility for different tasks of the organization. Subunits can be organized on the basis of:

- *Geography*, that is, communities of people living in close proximity, such as cities, towns, neighborhoods, or public housing areas; or

- *Affinity*, that is, communities of people with personal and working relationships, such as ethnic groups or business or religious organizations (Heller 1989). Community prevention efforts organized by affinity group may be:

  — *Institution-oriented organizations* in which subunits are created on the basis of institutional affiliation (e.g., schools, businesses, churches, and government); and/or

  — *Mission-oriented organizations* in which subunits are created on the basis of the type of issue or target population to be addressed (e.g., youth gangs, homelessness, perinatal addiction, families, and/or older people).

Leadership Type

Central to the issue of organizational structure is the question of who will take, and keep, the initiative. The initiators of a prevention effort may not be the best candidates to maintain the coalition. The leadership may need to change as the organization matures and primary activities and tasks change. Three types of leadership are common among community coalitions for substance abuse prevention as shown below.

Regardless of the type of leadership structure or size, a few core leaders tend to dominate activities (Roberts-DeGenaro 1986). However, the coalition resources and power must be allocated to maintain goodwill and smooth working relationships. If the proposed leadership structure supports a collaborative multiple leader approach with equal power among the major collaborating agencies, coalition members will need to determine who will be the fiscal agent for the organization and how power will be shared. The fiscal agent is the agency that will receive and manage the funds for the prevention project and, therefore, it will have the power to include or exclude coalition member agencies in the fiscal decisionmaking process. Therefore, development of rules supporting shared governance, possibly through memoranda of agreement, will help to promote equal responsibility and shared power. In the formative days of the coalition, members may want to experiment with different configurations of leadership to see which works best.

TYPES OF LEADERSHIP

- A single prominent leader, for example, the executive director of the agency organizing the community prevention effort or the elected chair of a steering committee or executive committee;
- Multiple leaders, for example, a council (or other governing body) with members representing the primary organizations involved in the prevention effort who have equal votes and equal leadership responsibility; and
- Broad-based leadership, for example, a steering committee and/or an advisory committee as well as a director, program managers, and subcommittee chairs, with leadership shared across a number of management committees.

Leadership Style

Regardless of the type of organization and leadership structure chosen, the choice of a leader or leaders should be considered with care. The leadership type and the leader's style will set the tone for the organization in many significant ways. A leader's characteristics (e.g., personality, organizational ability, and willingness to delegate authority) are critical to positive outcomes. The strength and personal characteristics of coalition leaders are the most important factors in maintaining effective team efforts (Washnis 1976).

Leadership style is particularly critical in prevention organizations that rely heavily on volunteers. Volunteers are not bound by payment and if they feel their talents are not recognized and used effectively, they simply may leave the organization (Kumpfer et al. 1993). Coalitions that rely heavily on committed and charismatic leaders who are capable of mobilizing volunteers from many different segments of the community have been found to have the lowest leadership turnover of all substance abuse coalitions (Robert Wood Johnson Foundation 1989).

Leadership characteristics that are associated with the successful implementation and maintenance of community coalitions include those listed on the next page.

LEADERSHIP CHARACTERISTICS

- An empowering style of leadership with the ability to promote equal status, encourage collaboration, and support and reward members' efforts (Yates 1973; Mayer and Blake 1981; Kumpfer et al. 1993);
- Decisionmaking skills and flexibility (Miller et al. 1979; Knoke and Wood 1981);
- A high level of networking and visibility of membership in key community organizations and easy access to media and other needed resources (Schoenberg and Rosenbaum 1980);
- Political effectiveness and high level of political knowledge (Yates 1973); and
- Personal competencies such as individual efficiency, high level of education, administrative skills, and interpersonal skills in negotiations, conflict resolution, and problemsolving skills (Butterfoss et al. 1993).

Opportunities for participation in decisionmaking and planning increase members' involvement and satisfaction with the coalition and contribute to increased commitment and outcome effectiveness (Giamartino and Wandersman 1983; Knoke and Wood 1981). From the standpoint of the coalition members, successful leaders:

- Are more visible and involved;
- Promote cohesion and involvement;
- Support members' planning and decisionmaking;
- Provide opportunities for active contributions outside of meetings;
- Are attentive and supportive of members' issues and concerns; and
- Are empowering and supportive of members' efforts.

Determining the Type of Organizational Model

Before identifying the community leaders and organizational partners for a prevention effort, the initiators must determine the type of organizational model that is to be created. This will affect the balance of professional and nonprofessional persons, prospective partners, the defined community, the organization's scope of activities, and the guiding philosophy and vision for the prevention effort.

Three major types of community organizational models have been adopted by coalitions to address substance abuse and other health problems (Pentz 1986). The three models include:

- A *professional model* consisting primarily of paid professional staff members;
- A *grassroots or lay model* consisting primarily of volunteers and community organizers; and
- A *joint professionally supported community empowerment model* consisting of a balance of both paid professionals and volunteers.

Community attitudes will help determine which is the best model. Unfortunately, there are no research data supporting the success of any one model over the others. Some communities have a history of grassroots involvement whereas other communities expect professionals to conduct prevention activities. The type of community organization to be created will impact recruitment of members for the coalition. The composition and percentage of community members versus paid professionals may depend on a number of factors, but the following questions can help guide the decision about which model can be created and who can be invited to participate in the coalition.

- How broad an effort is really desired?
- Do concerned agencies desire a coalition of professionals to lead their efforts?
- Is this professional collaboration all that is desired?
- Is the coalition to be expanded by adding a community advisory element?
- Is the coalition to be a transitional step toward a community organization with professional advisors?

- Is the ultimate goal a completely independent community organization?

- Will a professionally run coalition exist alongside another model?

Identifying and Selecting Potential Coalition Members

The composition of a prevention coalition may be approached by determining the groups and individuals in the community who have sufficient interest to make a lasting commitment to participating in the coalition, the kinds of resources they likely will commit, and how many of them likely will make a significant commitment to the effort. Many individuals and representatives of community organizations will find it awkward to say no or easy to say yes to requests to participate in an effort so clearly civic- and community-minded, but how many will follow through? Preliminary answers to these questions will tell the coalition initiators how broadly to cast their net in looking for potential coalition members.

A major reason for developing a collaborative community prevention effort is to increase the political will to act and mobilize manpower and fiscal resources. Therefore, each member will bring a different set of resources and skills to the coalition. Diversity enables the coalition to represent and reach a large constituency.

Criteria for Membership

There are three essential characteristics to consider in the determination of whom to invite to participate in the coalition:

- *Diversity*. Include a broad range of agencies and groups with an interest in the problem. The groups can represent a wide range of skills across diverse ethnic and cultural perspectives. Although different backgrounds can put additional stress on shared understandings and communication, diversity is essential to ensure that the cultural norms and realities of the community as a whole are represented adequately and appropriately.

- *Commitment*. The prospective members can manifest commitment to the shared coalition vision over their own vested interests.

- *Clout*. The members can represent their own organizations at a high enough level that they have the authority to act on behalf of and commit resources from their agencies.

Frequent Partners in Community Coalitions

According to the Robert Wood Johnson Join Together Coalition surveys (Join Together 1993, pp. 1-32), typical members of substance abuse prevention coalitions include representatives from the following sectors of the community. The percentages of time the surveys found these agencies involved in community substance abuse prevention efforts are shown in parentheses.

- Schools (90 percent): Because schools are a major way to access youth with prevention strategies, it is essential to involve them. It is critical to involve the superintendent, principals, school board members, teachers, and PTAs.

- Law Enforcement (85 percent): The chief of police, local Drug Enforcement Administration (DEA) administrator, county sheriff, and highway patrol are important to include in the coalition.

- Alcohol and Drug Abuse Prevention Agencies (76 percent): The directors of the single State and county agencies for substance abuse will be important participants to invite to the coalition. These persons are likely to designate their prevention coordinators to attend coalition meetings. They also will have lists of all prevention providers they support in the local community.

- Parents (72 percent): A good source of parents who are likely to participate in the coalition can be those in parent organizations committed to substance abuse prevention, such as PTAs, Al-Anon, and general parent support groups.

- Volunteers (71 percent): Community volunteers can be sought through fraternities and sororities, civic action groups, and other groups dedicated to community service.

- Treatment Providers (70 percent): State and county substance abuse treatment agencies can provide lists of licensed alcohol and other drug treatment providers in the local community who can be tapped for participation in the coalition.

- Local Governments (67 percent): A governor, mayor, county commissioner, head of health and human services, and substance abuse prevention director can be invited to participate in the coalition. These key leaders may not participate directly but will recognize the coalition by designating a representative to attend coalition meetings.

- Other groups: According to the Join Together (1993) surveys of coalition participants, the following groups are frequently represented in coalitions:

  — Youth (64 percent);

  — Private business (63 percent);

  — Government/human services (62 percent);

  — Courts/probation staff (61 percent);

  — Religious organizations (61 percent);

  — Government/health services (56 percent);

  — People in recovery (55 percent); and

  — Other concerned citizens (54 percent).

Infrequent Partners in Community Coalitions

According to the Join Together Coalition surveys (1993), labor organizations, the transportation industry, employment services, public assistance agencies, the alcohol and beverage control industry, and citizen action groups were members of fewer than 30 percent of substance abuse coalitions. Other groups represented in fewer than 50 percent of coalitions include:

- Private health and human services agencies;
- Universities;
- Mass media;
- Child protective service agencies;
- Recreation departments;
- Civic or fraternal organizations; and
- Housing organizations.

Locating Community Associations for Participation

The more localized the definition of the target community, the more closely the community should look within itself for community partners and coalition participants. The organizations identified for possible participation in the coalition, both public and private, will be important channels through which to deliver drug abuse prevention messages and sources for coalition members as well as sources of workers when a job needs to be done. Community associations are identified in a variety of ways, as shown in the chart on the following page.

Anticipating Problems

Recruiting members for the coalition will take time. During this time, strategies should be developed for addressing potential problems and dealing with potential adversaries and turning them into allies. A major hazard to avoid in developing a coalition is not taking the time to involve key players who could easily undermine or stop efforts proposed by the coalition. Other problems relate to the following issues:

- Defining the relevant community;
- Identifying the target populations;
- Determining a shared vision; and
- Starting small.

Defining the Relevant Community

The community or communities to which prevention efforts will be directed must be clearly defined. As indicated earlier, a community can be defined by geographic location or affinity group. If the target community has been chosen on the basis of geographic location, it also will have an element of self-identification, that is, a sense of where we stop and they start. Every resident belongs to and participates in a several overlapping communities. However, the geographic element, corresponding to "our part of town," is likely to be the key determinant of the community to which the citizen belongs.

For example, in a small community, the entire town may be the appropriate unit of community. However, it should be remembered that too ambitious a definition of the target community can increase the difficulty of organizing a coalition and diminish the coalition's chance of having a significant impact.

LOCATING COMMUNITY ASSOCIATIONS

- *Through lists of existing human services organizations.* Many large and some small municipalities maintain directories of social, health, or human services organizations. These directories are a good place to begin the process of developing a list of potential coalition members. Other sources for lists include reference desks in public libraries and chambers of commerce and telephone Yellow Pages listings of "Associations" and "Organizations."

- *Through inventories of local prevention program providers.* Surveys of community agencies that provide substance abuse prevention and/or treatment services can offer a compilation of information from the general knowledge of program staff. Asking staff members of the identified agencies also can result in the identification of other potential agencies. Respondents can be urged to err on the side of inclusiveness by identifying agencies that have *any* significant contact with at-risk populations.

- *Through newspapers.* Reviews of major and community newspapers may reveal news items and notices of meetings of organizations of interest to the coalition.

- *Through small community-action organizations.* Excursions into the community may reveal places where flyers are posted (e.g., supermarkets, laundromats, libraries, transit stops and neighborhood restaurants). Places where people frequently pass by or spend time in large groups are important sites where community-action organizations should post flyers.

- *Through popular meeting places.* Staff can be contacted in places where groups meet, such as churches, libraries, parks and recreational facilities, and meeting halls of fraternal and civic organizations. It is wise to talk to directors, managers, and/or secretaries in these places who can provide assistance in identifying relevant organizations for the coalition. Churches often sponsor or provide meeting space for substance-abuse-related groups and can be of particular assistance in the search.

- *Through contacts with local citizens.* It is wise to ask people in the community, for example, shop owners, beat police,or teachers in local schools, for help in identifying any organizations that have been omitted from the lists.

Identifying the Target Populations

In addition to determining the communities within which to work, it is necessary to define the target populations. Will the coalition focus only on youth, or will it also address young adults, adults, and older people? The needs assessment data should help coalition organizers determine where to focus the prevention efforts.

Determining a Shared Vision

At the beginning of the community organizing process, it is important to develop a guiding philosophy that incorporates a shared vision that all agree upon. The initial organizers will find it easier to determine which agencies or partners to recruit if they determine the mission, the guiding philosophy, the unifying theme, and a shared vision of the coalition. These may seem like illusive ideas, but they are important in getting acceptance from potential coalition members.

The mission of most substance abuse prevention coalitions is to reduce substance abuse. Nevertheless, individuals may have different perceptions of the program's ultimate purpose unless it is made explicit and all have an opportunity to develop a sense of ownership. It is important to ensure that everyone shares the same vision, as well as a common philosophy about how to realize it. Do members agree that substance abuse is a problem and needs to be addressed? Do partners agree that collaborative efforts will be encouraged at all times in partnership projects? Once the loyalty of prevention coalition members is confirmed, use of unifying themes, slogans, short phrases, or statements can be used by the coalition to convey and reinforce the prevention message quickly. These slogans are developed locally and convey a message that all agree with and understand. Sometimes slogans are accompanied by a logo for the coalition and put on T-shirts and stationery.

Starting Small

There are significant advantages to starting small and learning lessons and skills that can be enlarged on later. Starting small does not mean that some elements of a larger community must be excluded from participating in the community coalition. Perhaps initially, if staff and other resources are limited, some segments of the community may be excluded. But there is no reason that two or more coalitions cannot ultimately exist side by side in a large city. Not all segments of the community within a given municipality will be equally ready and/or willing to mobilize to participate in a coalition. Therefore, it may be better to start with those who are ready and willing. A successful effort in one community segment will often generate a demand by another segment to be let in.

Getting Started

The following discussion is intended to help guide a community through the process of organizing and convening the first community meeting to establish a drug abuse prevention coalition. This process is presented only for illustrative purposes and is not intended to be a model undertaken in all community contexts.

Creating an Organizing Committee

After all the preliminary work for a community substance abuse prevention initiative has been accomplished, the next step in the development of a community coalition will be the creation of an organizing committee, consisting of 15 to 20 members, to assume the responsibility for convening an organizing meeting and seeing that the community is broadly and appropriately represented. The organizing committee should comprise two kinds of people—highly visible leaders whose blessing will help ensure success and lower profile leaders or working-level organizers who will actively participate in the effort.

High-Profile Organizers

The participation of highly visible leaders will help lend credibility to the effort in the public's eyes and help improve cooperation within public agencies. The mayor, chief of police, county commissioner, superintendent of schools, and head of the chamber of commerce all fall into this category. Their signature on a letter or presence on the speakers' platform or at an event sends an important message. They probably will be represented at subsequent meetings by staff members whose program responsibilities are directly related to the purpose of the coalition.

Working-Level Organizers

Alcohol and drug abuse prevention agencies can be represented on the organizing committee by a senior official, although not necessarily the agency head. Parent organizations, a broad representation of religious organizations, and the media, business, and education communities all can have senior representatives. One or two independent citizen-activists with a demonstrated interest in substance abuse also should be included as well as other infrequent partners mentioned earlier.

Calling the First Organizing Meeting

With the organizing committee established, coalition initiators can choose a time, date, and meeting place on neutral territory that is readily accessible and has convenient parking. In choosing a hall or room, it should be remembered that only a fraction of those invited will attend;

therefore, a standing-room-only turnout will convey a more satisfactory message to the community than the same number of people huddled halfway back in a large auditorium. Media can be invited to cover the event and given press packets that have been prepared with the input of the media advisory group. The steps listed in the chart on the next page may be helpful in preparing for the meeting.

Conducting the First Organizing Meeting

The general tone of the first meeting must be carefully designed because it will substantially affect the willingness of some agencies to become involved. A climate of collaboration, inclusion, and shared leadership is desirable. Following the chart listing steps for the first organizing meeting is a sample agenda of major points that can be addressed at this meeting. It is presented here merely as a guide for conducting the meeting. The particular items and their placement on a meeting agenda will be dictated by the needs, interests, and goals of the particular community. Therefore, these sample agenda items should not be considered as standard for all circumstances in which a community is organizing for a substance abuse prevention effort.

Some agenda items are of particular importance for all coalitions and therefore should be specifically addressed during the first organizing meeting. These items include:

- Introduction to the local problem;
- Stating the goal and objectives of the organizing meeting;
- Discussing whether collaboration will work;
- Creating an organizational structure;
- Enlistment and survey of volunteers; and
- Celebrating

Introduction to the Local Problem

A short summary of the results of the needs assessment, including a survey of key leaders and community attitudes, can be presented at the beginning of the meeting. Workers who participated in the data collection for the needs assessment can be acknowledged and the community members who participated in the surveys thanked. If it is available, a short video of the local problem can be interesting and stimulate motivation to participate.

FIRST ORGANIZING MEETING

- *Letter of invitation*. Formal letters of invitation to the first organizing meeting can be sent to the heads of all the identified groups. The purpose of the meeting, as well as an agenda and details about the date, time, and place should be included. Invitations sent by first class mail will be given more attention than those sent by bulk mail. A reply can be requested, and if possible, the reply can be directed to the office of the highest profile official involved, ideally the mayor but *not* the chief of police so as to avoid the appearance that the proposed prevention effort is primarily a law enforcement issue. The RSVP will increase the seriousness with which the invitation is taken. Although not all who RSVP will attend, and many will attend who do not RSVP, the results will help predict attendance.

- *Community publicity*. Conduct an issue awareness campaign to draw attention to the organization meeting. The broadcast message is that everyone is invited to attend. Radio and television public service announcements, news releases, broadcast media coverage stressing the broad base of sponsorship and notices and articles in community, church, and other organization newsletters will be helpful. The broadest possible participation can be the goal to avoid to the extent possible any appearance or charge of exclusivity. Inclusion of all identifiable ethnic groups is particularly important.

- *Selecting a chairperson for the organizing meeting*. A successful organizing meeting requires a careful balance of structure and spontaneity, of expectation and openness. Above all, it requires a chairperson who is widely respected and also experienced and forceful in the conduct of a public meeting. The chairperson will need to conduct the meeting with openness but also with a determination to move to a productive conclusion within a reasonable time limit. Efficient conduct of the meeting will ensure its productive conclusion. In the likely event the meeting will be held in the evening, ensure that film footage shot during the meeting will be available for the local evening newscast. It may be desirable to identify a chairperson who will *not* have a continuing role in the coalition and therefore more likely will be seen as fair and impartial.

AGENDA FOR FIRST MEETING

A. Welcome: Meeting Chairperson and Community Leader (Mayor, Councilperson, et cetera)

B. Introduction of Organizing Committee Members

C. Introduction to the Problem

D. Statement of Goals and Objectives of the Coalition

E. Discussion: Pros and Cons of Collaboration

F. Discussion: Possible Organizational Structure

G. Election of Coalition Officers

H. Survey of Volunteer Assets

I. Task Assignments for Next Meeting

J. Time and Location of Next Meeting

Stating the Goal and Objectives of the Organizing Meeting

The goal and objectives of the organizing meeting should be stated clearly at the outset because they will provide a standard for addressing future issues raised at subsequent meetings. The chairperson can broach the question of whether the problem of substance abuse in the community requires a broad community effort and set an explicit time limit for individual speakers for this phase of the meeting. Participation in this stage of the discussion often will give an indication of the balance between residents and professionals that is likely to emerge in the coalition effort.

Discussing Whether Collaboration Will Work

Participants can discuss their willingness to work together. The expectations of the major organizational partners must be specified. Preparation for this type of commitment can be made before the meeting by identifying individuals who will agree to make commitments on behalf of their respective organizations at the meeting. The benefits as well as the costs of collaboration can be candidly addressed.

Creating an Organizational Structure

If consensus is to reached to create a community coalition, then, depending on the size of the group, its diversity, and the apparent degree of consensus, it may be appropriate to conclude the meeting with the creation of a governing body, for example, a council of 12 to 15 members. Nominations can be made from the floor and the specific expectations and responsibilities of the council clearly explained that informed nominations can be made. If the number of nominations is large, the simplest election is one in which each person present votes for one name, and the 12 or 15 who receive the largest number of votes are declared elected.

The council can be charged with creating the coalition organization (e.g., a steering committee, executive committee or advisory committees, and subcommittees) and electing a chairperson. Subcommittees can be established to address areas such as needs assessment, communications, strategic planning, programs, and evaluation. If the meeting has gone smoothly, a high degree of consensus is apparent, and if time allows, establishing subcommittees may be done at the organizing meeting. The decision on how and when to organize can be made by the council. The newly elected council members can come forward and take seats in the front of the room so that they are clearly identified.

Enlistment and Survey of Volunteers

Before concluding the meeting, the chairperson can stress the role of the council as that of representing the much larger group of interested individuals and organizations. All attendees can be urged to complete a simple survey of their specific areas of interest in drug abuse prevention and their ability to participate in the work of the coalition and its working groups. The survey forms might include questions about the volunteers' interests in serving on either institution-oriented working groups (e.g., schools, businesses, or churches) or problem-oriented working groups (e.g., youth gangs, pregnant teens, or addicted mothers). A comprehensive survey of volunteer assets can be accomplished through use of a capacity inventory such as that found in *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets* (Kretzmann and McKnight 1993), which can be ordered from local bookstores. No

one should leave the organizing meeting feeling that their opinions or contributions are unwanted or unwelcome.

Celebrations

At the end of the first meeting, a celebration can be held and open to all attendees. In some communities, having food and entertainment is a must for almost all community gatherings and creates an atmosphere of friendship, cooperation, and fun. To reflect on progress and reward participants in the early organizing work, some coalitions have taken slides or videos of the volunteers working on the needs assessments, in planning meetings, mailing out the invitations, and other activities and shown them at the celebration. These visuals help acknowledge and reward all the volunteers who have participated in the beginning effort.

Evaluation of Coalition Activities

Finally, an important aspect in the development and maintenance of communitywide prevention efforts and for increasing the effectiveness of the coalition is evaluation. In this context, evaluation refers to the systematic and objective measurement of the process through which the coalition develops as an organization and the outcomes it achieves toward substance abuse prevention. According to Goodman and Wandersman (1994), objective evaluation of all aspects of the prevention effort:

- Is an ongoing and dynamic process;
- Is a collaborative process;
- Keeps coalition expectations simple, realistic and measurable;
- Guides ongoing coalition development; and
- Measures both the processes and outcomes of the coalitions efforts.

Regardless of the specific evaluation methodology used, planning for evaluation can be incorporated into the structure and activities of the coalition from the beginning of the initiative. Professional evaluators also can help the coalition define its goals and objectives in ways that can be measured, support the development of logic models and program plans, advise on the success of prior prevention programs, and provide valuable feedback about the impact of the prevention programs.

NIDA has produced an RDA package on program evaluation, *How Good is Your Drug Treatment Program?*, that can be useful for community coalitions seeking to evaluate their prevention efforts. Although this program evaluation package was developed for drug abuse treatment programs, it contains important information about evaluation purposes and strategies that also applies to prevention programs. Evaluation guides that focus on prevention programs include *The Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP)* and *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities*. For information on obtaining these materials, see appendix A.

SUMMARY AND CONCLUSIONS

The purpose of this resource manual is to present the concept of community readiness for drug abuse prevention programming, describe factors associated with readiness to implement a prevention effort, and suggest strategies or steps communities can take to improve their readiness by strengthening factors that are weak. This manual is intended for use by prevention practitioners, including program administrators, prevention specialists, community volunteers, parents, teachers, businesses, and other groups and individuals concerned about the problems of drug abuse and its prevention. The primary objectives of this resource manual are to provide guidance in the application of the strategies to increase community readiness and motivate members of the target audience to consider community readiness issues in their planning for community prevention efforts. Appendix B provides a detailed case study that illustrates how a community coalition can assess factors associated with readiness and develop strategies for strengthening areas of deficiency and improve readiness.

This resource manual along with the other documents in this NIDA RDA set of materials, is intended to be a guide to help communities address their substance abuse problems through communitywide efforts of professionals, non-professionals, community agencies, and organizations that are committed to prevention. In addition to a presentation of the key factors for assessing and improving community readiness, this manual provides the rationale and step-by-step guidance for the development of a community prevention coalition that can serve as the focal point for the development and maintenance of community prevention activities.

The information provided in this resource manual is extensive, but it is by no means exhaustive. As communities progress in their efforts to implement communitywide substance abuse prevention programs, they undoubtedly will face more questions and challenges. Therefore, it is the intention of NIDA, through this document, to provide a source of guidance and support for communities to assess and increase their readiness for the task that they undertake. Communities that are the most ready for and committed to drug abuse prevention will be those most likely to succeed in their implementation efforts. Although the journey will not always be easy, the ultimate destination to be achieved surely will be worth the trip.

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APPENDIX A: RESOURCES

CONTACTS AND RESOURCES: RESEARCH-BASED PREVENTION MODELS FOR DRUG ABUSE

The following substance abuse prevention program models are highlighted in the *Drug Abuse Prevention RDA* set of materials. The name and address of the principal investigator conducting the research for each model is provided, followed by information on the availability of training manuals, formal training services, consultation, and technical assistance.

Project STAR, a communitywide prevention program:

Mary Ann Pentz, Ph.D.
Department of Preventive Medicine
University of Southern California
1540 Alcazar Avenue, Suite 207
Los Angeles, CA 90033
Phone: (213) 342-2582
Fax: (714) 494-7771

Manuals, training, and technical assistance services are available from the research group at the University of Southern California, as follows:

- School component—teacher and peer leader training, manuals, and parent-child workbook;
- Parent component—parent and school principal training, manuals, and parent-child workbook;
- Community organization component—training;
- Policy component—training;
- Media component—training; and
- Evaluation—evaluation instruments, services, and data collection training tape.

Training costs are $150 to $250 per person per day, from a minimum of $1,500 up to a maximum of $2,500 per day, depending on the nature of the presentation. Technical assistance costs are negotiated on a case-by-case basis. Further information about materials, training, or technical assistance also can be obtained by contacting:

Project I-STAR
5559 West 73rd Street
Indianapolis, IN 46268
Phone: (317) 291-6844

Strengthening Families, a family-focused prevention program for children of substance-abusing parents:

Karol L. Kumpfer, Ph.D.
Department of Health Education
HPERN-215
University of Utah
Salt Lake City, UT 84112
Phone: (801) 581-7718
Fax: (801) 581-5872

Manuals, training, and evaluation services and instruments are available from the program developers, evaluators, or implementors by contacting Dr. Kumpfer. A 3-day training costs $2,000 plus travel for a group of up to 16 participants.

Costs for program materials are:

Family Training Therapist Manual	$ 25
Parents' Skills Training Manual	25
Parent Handbook	25
Children's Skills Training Manual	25
Children's Handbook (6 to 12 years)	25
Implementation Manual	25
Evaluation Package	25
7-Manual Package Total:	$175
African-American Parent Handbook	25
8-Manual Package Total:	$200

Reconnecting Youth, a school-based prevention program for at-risk youth:

Leona L. Eggert, Ph.D., R.N.
Psychosocial and Community Health Department
P.O. Box 357263
University of Washington
Seattle, WA 98195
Phone: (206) 543-9455 or 543-6960
Fax: (206) 685-9551
e-mail: eggert@u.washington.edu

Consultation and technical assistance are available by contacting Dr. Eggert. Materials and training are also available. Program awareness can be gained in a day. Full-scale training requires 3 to 5 days and is limited to small groups. Prices for the training vary depending on the number of people to be trained. Rates are structured on an honorarium-plus-expenses basis. A curriculum and leaders' guide, *Reconnecting Youth: A Peer Group Approach to Building Life Skills*, is available for $139. For materials and training, contact:

Susan Dunker or Peter Brooks
National Educational Service
1252 Loesch Road
P.O. Box 8,
Bloomington, IN 47402-0008
Phone: (812) 336-7700
Toll Free: (800) 733-6786
Fax: (812) 336-7790

CONTACTS AND RESOURCES: COMMUNITY READINESS FOR DRUG ABUSE PREVENTION

Eugene R. Oetting, Ph.D.
Scientific Director
Barbara Plested,
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Colorado State University
C79 Clark Building
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Abraham Wandersman, Ph.D.
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Columbia, SC 29208
Phone: (803) 777-7671
Fax: (803) 777-0558

SOURCES OF INFORMATION ON COMMUNITY COALITIONS

The Anti-Drug Abuse Act of 1988 provided congressional authorization and funding for the Center for Substance Abuse Prevention (CSAP) to create more than 250 community partnerships nationwide (Davis 1991). Additional community substance abuse prevention coalitions and community action groups have been implemented by:

- State and local governments, for example, Rhode Island (Florin et al. 1992b) and Oregon (Hawkins et al. 1992);

- National foundations, for example, Henry J. Kaiser Family Foundation (Tarlov et al. 1987) and Robert Wood Johnson Foundation Fighting Back and Join Together coalitions (Robert Wood Johnson Foundation 1989);

- Federal Public Health Service agencies, for example, the National Cancer Institute's COMMIT and ASSIST tobacco and cancer reduction programs (Best et al. 1988; Shopland 1989), the Planned Approach to Community Health (PATCH) health promotion program of the U.S. Centers for Disease Control and Prevention (Kreuter 1992), and the Weed and Seed Program of the Bureau of Justice Assistance; and

- Schools and universities, for example, the university coalitions sponsored by the Department of Education/Fund for the Improvement of Post-Secondary Education (DOE/FIPSE) and local school boards.

POTENTIAL FUNDING SOURCES

Federal Grants

Most Federal substance abuse funding is provided as either demonstration and evaluation grants or prevention research grants. These funding mechanisms require evaluations and data collection processes to determine the effectiveness of the programs. These are *not* service grants (See list of Federal Government agencies).

Potential Federal funding sources for *demonstration grants* include:

- Center for Substance Abuse Prevention (CSAP);
- Center for Substance Abuse Treatment (CSAT);
- Office of Juvenile Justice Delinquency Prevention (OJJDP);
- Bureau of Justice Assistance (BJA);
- U.S. Department of Housing and Urban Development (HUD); and

Potential Federal funding sources for *research grants* include:

- National Institute on Drug Abuse (NIDA);
- National Institute on Alcohol Abuse and Alcoholism (NIAAA); and
- National Institute of Mental Health (NIMH).

Other Grants

Service grants are available through individual State block grant mechanisms or through local county funding sources.

FEDERAL GOVERNMENT AGENCIES

Bureau of Justice Assistance (BJA)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 514-6278

Implements national and multistate programs, offers training and technical assistance, establishes demonstration programs, and conducts research to reduce crime, enforce drug laws, and improve the functioning of the criminal justice system. Offers the following information clearinghouse:

Bureau of Justice Assistance Clearinghouse (BJAC): (800) 688-4252

Bureau of Justice Statistics (BJS)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 29531
Phone: (202) 307-0765

Focuses on drugs and crime data and covers law enforcement and crime rates. Offers the following information clearinghouses:

BJS Automated Information System
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Offers drug- and crime-related information and materials. Fax-on-demand and Internet services also available.

BJS Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Distributes drug- and crime-related publications.

Center for Substance Abuse Prevention (CSAP)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0365

Focuses attention and funding on the prevention of substance abuse. Offers the following hotline:

Drug-Free Workplace Helpline (DFWH): (800) 843-4971

Center for Substance Abuse Treatment (CSAT)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-5052

Focuses attention and funding on the development and assessment of treatment techniques and models. Offers the following hotline:

CSAT's National Drug Information and Treatment Referral Hotline: (800) 662-4357

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-3311 or 3534

Researches and develops cures for diseases worldwide. Offers the following information clearinghouse:

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
Phone: (800) 458-5231

Offers information on AIDS-related resources and services. Publications are also available on substance abuse issues related to HIV.

Crime Prevention and Security Division
U.S. Department of Housing and Urban Development
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-1197

Awards drug elimination grants each year. Offers the following information clearinghouse:

> Drug Information and Strategies Clearinghouse
> P.O. Box 6424
> Rockville, MD 20849
> Phone: (800) 578-3472
>
> Distributes materials on substance abuse prevention in public housing.

U.S. Department of Housing and Urban Development (HUD)
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-0685

Focuses on all aspects of housing. Community programs target at-risk youth and work to improve neighborhoods.

Fund for the Improvement of Post-Secondary Education (FIPSE)
U.S. Department of Education
Seventh and D Streets, S.W.
Room 3100
Washington, DC 20202-5175
Phone: (202) 708-5750

Funds drug and violence prevention programs aimed at students enrolled in institutions of higher education. Program encourages colleges and universities to develop programs to prevent alcohol and other drug use for their students and staff.

U.S. Government Printing Office (GPO)
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Phone: (202) 783-3238
Fax: (202) 512-2250

Publishes and makes available numerous publications on many topics, including substance abuse. Many publications are available free of charge.

National Clearinghouse on Child Abuse and Neglect (NCCAN) Information
P.O. Box 1182
Washington, DC 20013-1182
Phone: (703) 385-7565
Phone: (800) 394-3366

Serves as a major resource center for the acquisition and dissemination of child abuse and neglect materials; free publications catalog on request.

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
Phone: (800) 729-6686
TDD: (800) 487-4889

Houses and catalogs numerous publications on all aspects of substance abuse. Provides computerized literature searches and copies of publications, many free of charge.

National Institute of Justice (NIJ)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-2942

Conducts research and sponsors the development of programs to prevent and reduce crime and improve the criminal justice system.

National Institute of Mental Health (NIMH)
U.S. Department of Health and Human Services
5600 Fishers Lane
Room 7C-02
Rockville, MD 20854
Phone: (301) 443-4513

Focuses on research in mental health and related issues.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-3860

Focuses attention and funding on research on alcohol abuse and alcoholism and their treatment.

National Institute on Drug Abuse (NIDA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-6245

Contacts: William J. Bukoski, Ph.D.
Chief, Prevention Research Branch
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-1514

Susan L. David, M.P.H.
Coordinator, Epidemiology and Prevention Research
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-6543

Focuses attention and funding on research on substance abuse and its treatment and on the dissemination and application of this research.

National Technical Information Service (NTIS)
Order Desk
5285 Port Royal Road
Springfield, VA 22161
Phone: (703) 487-4650
Fax: (703) 321-8547
Fax Receipt Verification: (703) 487-4679
RUSH Service: (800) 553-NTIS (additional fee)

Makes available numerous publications on many topics, including substance abuse.

Office of Justice Programs (OJP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5933

Operates many programs to prevent and treat substance abuse-related crime.

Office of Juvenile Justice Delinquency Prevention (OJJDP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5911

Focuses on program development and research to prevent and treat delinquency in at-risk youth. Offers the following information clearinghouse:

Juvenile Justice Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (800) 638-8736

Provides publications on juvenile crime and drug-related issues.

Office of National Drug Control Policy (ONDCP)
Executive Office of the President
Washington, DC 20500
Phone: (202) 467-9800

Is responsible for national drug control strategy; sets priorities for criminal justice, drug treatment, education, community action, and research. Offers the following information clearinghouse:

Drugs and Crime Clearinghouse
160 Research Boulevard
Rockville, MD 20850
Phone: (800) 666-3332

Distributes statistics and drug-related crime information.

Safe Drug-Free School Program
U.S. Department of Education
600 Independence Avenue, S.W.
Washington, DC 20202
Phone: (202) 260-3954

Funds drug and violence prevention programs that target school-age children. Training and publications are also available.

OTHER PREVENTION PROGRAMS AND ORGANIZATIONS

The following list of programs, organizations, and hotlines is provided for the reader seeking additional resources. Inclusion on this list should not be construed as an endorsement by NIDA.

Community Anti-Drug Coalition of America (CADCA)
901 North Pitt Street
Suite 300
Alexandria, VA 22314
Phone: (703) 706-0560
Fax: (703) 706-0565

A membership organization for community alcohol and other drug prevention coalitions, with a current membership of more than 3,500 coalition members. Provides training and technical assistance and publications and advocacy services and hosts a National Leadership Forum annually.

Narcotics Education
6830 Laurel Street, N.W.
Washington, DC 20012
Phone: (202) 722-6740
Phone: (800) 548-8700

Publishes pamphlets, books, teaching aids, posters, audiovisual aids, and prevention materials designed for classroom use on narcotics and other substance abuse.

National Center for the Advancement of Prevention
11140 Rockville Pike
Suite 600
Rockville, MD 20852
Phone: (301) 984-6500

Produces documents on a variety of prevention and community mobilization and readiness topics.

National Families in Action
2296 Henderson Mill Road, Suite 300
Atlanta, GA 30345
Phone: (404) 934-6364

Maintains a drug information center with more than 200,000 documents; publishes *Drug Abuse Update*, a quarterly journal containing abstracts of articles published in journals, academic articles, and newspapers on drug abuse and other drug issues.

Parents Resource Institute for Drug Education, Inc. (PRIDE)
3610 Dekalb Technology Parkway, Suite 105
Atlanta, GA 30303
Phone: (770) 458-9900
Phone: (800) 241-9746

Offers drug prevention consultant services to parent groups, school personnel, and youth groups. In addition, provides drug prevention technical assistance services, materials, and audio and visual aids.

Partnership for a Drug-Free America
405 Lexington Avenue
16th Floor
New York, NY 10174
Phone: (212) 922-1560

Conducts advertising and media campaigns to promote awareness of substance abuse issues.

Prevention First Inc.
2800 Montvale Drive
Springfield, IL 62704
Phone: (312) 793-7353

Produces a variety of print and audiovisual products on various prevention topics.

TARGET
National Northwest Federation of State High School Associations
11724 Plaza Circle
P.O. Box 20626
Kansas City, MO 64195
Phone: (816) 464-5400

Offers workshops, training seminars, and an information bank on substance use and prevention.

Toughlove International
P.O. Box 1069
Doylestown, PA 18901
Phone: (215) 348-7090
Phone: (800) 333-1069

National self-help group for parents, children, and communities, emphasizing cooperation, personal initiative, avoidance of blame, and action. Publishes a newsletter, brochures, and books. Holds workshops.

Hotlines

Al-Anon Family Group Headquarters
Phone: (800) 356-9996

Provides printed materials specifically aimed at helping families dealing with the problems of alcoholism. Available 9 a.m. to 4:30 p.m. EST.

Alcohol and Drug Hotline
Phone: (800) 821-4357
Phone: (801) 272-4357 in Utah

Provides referrals to local facilities where adolescents and adults can seek help. Operates 24 hours.

Child Help USA
Phone: (800) 422-4453

Provides crisis intervention and professional counseling on child abuse. Gives referrals to local social services groups offering counseling on child abuse. Operates 24 hours.

Covenant House Nineline
Phone: (800) 999-9999

Crisis line for youth, teens, and families. Locally based referrals throughout the United States. Help for youth and parents regarding drugs, abuse, homelessness, runaway children, and message relays. Operates 24 hours.

Depression, Awareness, Referral and Treatment (D/ART)
Phone: (800) 421-4211

Provides free brochures about the symptoms of depression, its debilitating effects on society, and information about where to get effective treatment. Operated by the National Institute on Mental Health. Operates 24 hours.

Grief Recovery Institute
Phone: (800) 445-4808

Provides counseling services on coping with loss. Available 9 a.m. to 5 p.m. PST.

National Mental Health Association (NMHA)
Phone: (800) 969-6642

Provides a recorded message for callers to request a pamphlet that includes general information about the organization, mental health, and warning signs of illness. Available 9 a.m. to 5 p.m. EST.

GENERAL PUBLICATIONS ON PREVENTION

The following publications are available from:

Join Together
441 Stuart Street, 6th Floor
Boston, MA 02116
Phone: (617) 437-1500
e-mail: jointogether.org

Alcohol and Drug Abuse in America: Policies for Prevention, 1995.
Recommendations on how communities can prevent alcohol and drug abuse.

Community Action Guide to Policies for Prevention, 1995.
Steps communities can take to strengthen prevention efforts.

How Do We Know We Are Making A Difference? 1996.
Eighty-six page substance abuse indicator's handbook to help communities assess substance abuse problems.

Substance Abuse Strategies in America's 20 Largest Cities, 1996.
Efforts against alcohol and drugs in 20 cities in the United States.

GOVERNMENT PUBLICATIONS

National Institute on Drug Abuse
Research Dissemination and Application Packages (NIDA RDA Packages)

NIDA RDA packages are available from the National Clearinghouse for Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), and/or the U.S. Government Printing Office (GPO). (See list of Federal Government agencies.) NCADI, NTIS, and GPO publication numbers and costs are listed for each RDA package.

Drug Abuse Prevention Package (4 publications), NCADI Order No. PREVPK

This package is designed to help prevention practitioners plan and implement more effective prevention programs based on evidence from research about what works. The core package should be ordered and read first because it provides the information needed to prepare communities for prevention programming. Three stand-alone resource manuals then can be ordered. These manuals each provide information and guidance on implementing a specific prevention strategy introduced in the core package. The core package is available free of charge from NCADI (Order No. PREVPK) while supplies last.

- *Brochure*
- *Drug Abuse Prevention: What Works*
- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*
- *Drug Abuse Prevention and Community Readiness Training Facilitator's Manual*

Drug Abuse Prevention Resource Manuals

These manuals are available free of charge from NCADI while supplies last.

- *Drug Abuse Prevention for the General Population*, NCADI Order No. BKD200

- *Drug Abuse Prevention for At-Risk Groups*, NCADI Order No. BKD201

- *Drug Abuse Prevention for At-Risk Individuals*, NCADI Order No. BKD202

How Good Is Your Drug Abuse Treatment Program Package (4 publications)

This package deals with treatment program evaluation; however, much of it is applicable to drug abuse prevention programming.

- NTIS #PB95-167268/BDL: $44.00 (domestic) + postage; $88.00 (foreign) + postage
- GPO #017-024-01554-7: $33.00 (foreign rate add 25-percent surcharge for special handling. If by airmail, an additional cost is added.)

Working With Families To Support Recovery Package (4 publications), NCADI Order No. FAMILYPK

This package is designed to disseminate research-based family therapy treatment approaches to the drug abuse field. It is available free of charge from NCADI while supplies last.

National Institute on Drug Abuse
Clinical Reports (NIDA Clinical Reports)

All NIDA Clinical Reports are available from NCADI. (See list of Federal Government agencies.) NCADI publication numbers are listed for each clinical report.

Family Dynamics and Interventions, NCADI Order No. BKD147

Mental Health Assessment and Diagnosis of Substance Abusers, NCADI Order No. BKD 148

National Institute on Drug Abuse
Research Monographs

All NIDA Research Monographs are available from NCADI. (See list of Federal Government agencies.) NCADI order numbers are listed for each research monograph.

Drugs and Violence: Causes, Correlates, and Consequences. NIDA Research Monograph 103, NCADI Order No. M103

Drug Abuse Prevention Intervention Research: Methodological Issues. NIDA Research Monograph 107, NCADI Order No. M107

Methodological Issues in Epidemiological, Prevention, and Treatment Research on Drug-Exposed Women and Their Children. NIDA Research Monograph 117, NCADI Order No. M117

Advances in Data Analysis for Prevention Intervention Research. NIDA Research Monograph 142, NCADI Order No. M142

Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions. NIDA Research Monograph 156, NCADI Order No. M156

National Institute on Drug Abuse
Videotapes for Prevention Practitioners

These videotapes are available from NCADI. (See list of Federal Government agencies.) Order numbers are provided for each tape.

Coming Together on Prevention, 1994, 27 minutes, NCADI Order No. VHS66, $8.50

Dual Diagnosis, 1993, NCADI Order No. VHS58, $8.50

Adolescent Treatment Approaches, 1991, NCADI Order No. VHS40, $8.50

National Institute on Drug Abuse
Other Publications

There are various other NIDA publications and products on various prevention and other related topics, some of which are listed below. For a full list, contact NCADI for a catalog. (See list of Federal Government agencies.) In addition, future products related to prevention will be announced through flyers and the *NIDA Notes* newsletter. Readers with access to computers can find out about new materials by calling up NIDA on its World Wide Web homepage at *http://www.nida.nih.gov/*

Drug Use Among Racial/Ethnic Minorities, NCADI Order No. BKD180

Monitoring the Future Survey—Prevalence of Various Drugs for 8th, 10th, and 12th Graders, 1996, NCADI Order No. BKD213

Center for Substance Abuse Prevention (CSAP)
Publications

CSAP has a wide range of prevention products addressing various prevention topics and targeted populations. These products include resource guides, manuals, pamphlets, posters, videotapes, and data reports. Target populations include educators, community leaders, families, health professionals, and youth. Publications are also available in Spanish. CSAP products are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog. Publications cited in this *Drug Abuse Prevention RDA package* are given below. NCADI publication numbers are listed for each publication.

Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5. Rockville, MD: NCADI Pub. No. BK170, 1993

Conducting Focus Groups With Young Children Requires Special Consideration and Techniques. CSAT Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS501, 1991 (Reprint 1994)

Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities. Center for Substance Abuse Prevention. DHHS Pub. No. (ADM)92-1884A. Rockville, MD, 1992

Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP). U.S. Department of Health and Human Services. DHHS Pub. No. (ADM)87-1512, Rockville, MD, 1987

Measurements in Prevention: A Manual on Selecting and Using Instruments To Evaluate Prevention Programs. CSAP Technical Assistance Report 8. Rockville, MD: NCADI Pub. No. BK213, 1993

Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community, Rockville, MD: NCADI Pub. No. BK159, 1991

Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level. Rockville, MD: NCADI Pub. No. BK18, 1991

Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms. Rockville, MD: NCADI Pub. No. PHD627, 1994

You Can Manage Focus Groups Effectively for Maximum Impact. CSAP Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS495, 1991 (Reprint 1994)

Center for Substance Abuse Treatment (CSAT) Publications

CSAT has two series of publications, some of whose issues address topics of interest to substance abuse prevention professionals. Topics include dual diagnosis, assessment and treatment of adolescents, and so forth. The two series are called Technical Assistance Publications Series (TAPS) and Treatment Improvement Protocol Series (TIPS). CSAT publications are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog.

Other Government Publications

The following publications are available from the agencies. (See list of Federal Government agencies.)

Supporting Substance-Abusing Families: A Technical Assistance Manual for the Head Start Management Team. Washington, DC: Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, 1994

Working With Parents: Grades 9-12, Learning To Live Drug Free: A Curriculum Model for Prevention. Washington, DC: Department of Education, May 1990.

APPENDIX B: CASE STUDY

Five Corners Community

I. DESCRIPTION OF THE COMMUNITY

Demographics

Setting. This is a 60-block residential community that, although generally self-sustaining, is part of a large metropolitan area in western United States. This community has an active community council that functions as a liaison with the city government. This neighborhood has a distinct boundary and shares common problems of neighborhood deterioration with one other inner-city neighborhood—West Central City. However, in comparison to West Central, Five Corners exhibits a major potential for revitalization because of its community pride, strength of community leadership, and community involvement. Community-based organizations work together for the common good in this neighborhood.

Population. Because it is a low-income, low-rent neighborhood, Five Corners has always had a racial mix, consisting primarily of European-American (43 percent), Mexican-American (35 percent), and Asian/Pacific Islander (22 percent) ethnic groups. About 22 percent of the residents were not born in the United States. Most of the immigrant population are Mexicans and Asians. Many residents maintain a strong sense of community and ethnic pride. People can be described as working class. Thirty-three percent of the people live in poverty.

Five Corners is a community that is beginning to develop big-city crime problems as a result of significant immigration of gang members from inner-city neighborhoods in the metropolitan area of which Five Corners is a part. Drive-by shootings, gang killings, graffiti, vandalism, and drug-related activities are increasing rapidly. Because of the large number of youth per capita (84 per 100 adults vs. 62 per 100 adults nationally) and high percentage (54 percent) of children raised in single parent families, the juvenile crime rate is already high. Hence, if the youth culture becomes increasingly influenced by antisocial elements or gang culture, this community has a potential for major substance abuse and juvenile delinquency problems.

Educational performance in Five Corners is also relatively lower than performance across the State. In 1990, 54.4 percent of those in the target neighborhood graduated from high school compared with a State average of 85.1 percent. Among ethnic students the high school dropout rate has increased to 85 percent from 63 percent ten years ago. Ethnic students report a negative school climate and increasing discrimination because of increased numbers of elite college preparatory students coming to Five Corners High School.

Schools in the target neighborhood report high turnover in the student population, averaging between 55 percent and 83 percent. Directly related to student turnover is the markedly low performance on the Standard Achievement Test (SAT) in Five Corners. Students in the fifth and eighth grades average below the 25th percentile on the Total Battery of the SAT. High rates of absenteeism, mobility, and poverty are some the underlying causes for the low test scores.

In 1995 approximately 21 percent of the 15,811 housing units in the target neighborhood were vacant or boarded up. The median home value is $33,425. Compared with 63 percent of the dwellings being owner occupied in 1970, by 1994 only 51 percent of the dwellings were owner occupied. These shifts in housing trends means a more transient, less stable population that has less interest in and commitment to the community. The shift also has contributed to school turnover and poor educational performance.

A higher rate of public assistance reflects the poverty problem in the target neighborhood. The median family annual income in the target neighborhood is $14,533. More than 33 percent of the residents earn incomes considered below the poverty level. Approximately 35 percent of the families in the target neighborhood are single parent families; but 54 percent of the children are being raised in single-parent families. More than 20 percent of the families receive some form of public assistance, and more than 29 percent of the population receives Social Security income.

A disproportionately high percentage of known fugitives is associated with the target neighborhood. The joint Federal, State, and local Violent Crimes Task Force confirmed that 30 percent of the 531 dangerous fugitives who were arrested since October 15, 1994, were arrested here.

Other. The businesses in this area are mostly family operated; however, there are some large warehouses and industrial areas in this neighborhood because the railroad runs through Five Corners. The entire large metropolitan area and region are experiencing an economic boom fueled by large numbers of businesses and people moving in from other parts of the State.

One high school, Five Corners, serves this community. Until 10 years ago, it had been considered the least desirable or prestigious of all city high schools. A new principal and some dedicated new teachers have changed the school around into the best high school. New accelerated college preparatory programs were added to the school curriculum.

There are many churches representing many faiths. There are several federally subsidized housing communities. Two city councilmembers live in this neighborhood. There is one outpatient alcohol and drug treatment facility operated by the community mental health system, colocated in the community health clinic on Center Street.

Impetus for Action

Drug-related crime and gang activities had been increasing in this neighborhood for years but recently have become intolerable to residents. Although in the past most drug activities were primarily isolated to a specific local park near the railroad station, recent drive-by shootings, drug-related muggings, and the proliferation of crack-houses and methamphetamine labs have made residents very worried about their personal safety.

On a late Friday afternoon in December 1993, five women and three men, all long-time residents of Five Corners, met in the community meeting room of the local Methodist Church to talk about the drug problem. They all were a little disappointed. Mr. Supi Maniu had made a tropical coconut punch, and Ms. Maria Salazar had brought Mexican cookies and cakes for 75 people. Ms. Salazar and Mr. Maniu had distributed 500 fliers, some in local stores, some on telephone poles, and the others under doors throughout the neighborhood, covering a 15-block area. Ms. Salazar paid for the 500 fliers herself and set the October meeting after Mr. Maniu got permission from the minister of the church.

Concern about the drug problem had been raised among many community members for many years. Concern crystallized for Ms. Salazar when her 13-year-old daughter was mugged on the way to school by a 17-year-old who was looking for money to buy crack. The youth was apprehended and convicted, but the incident so incensed Ms. Salazar that she has been on a mission ever since to get the dealers and users out of the neighborhood. The park in the neighborhood was known throughout the city as a quick and convenient place to score and had, throughout the years, had numerous drug raids, shootings,and turf wars between rival gangs. The burglary and robbery rates were high, but police attributed them to a large and growing number of homeless people who lived in abandoned and boarded-up buildings in the area.

Ms. Salazar was encouraged by local police when they said that the new crime bill had a lot of drug prevention money in it and that all she had to do was to get a group of people together to form some kind of committee; then the Federal Government would give them money to fight drugs. Ms. Salazar thought that it sounded good and has been trying to get a committee together. At this time, she was not working; but she had worked as a social worker and community development specialist for the Social Services Department in another State 10 years ago. She thought she could lead a community drug prevention program effectively and wanted to get more involved in the community once her youngest child was 13 years old.

The Salazar family moved to Five Corners because Mr. Salazar worked at one of the nearby industrial plants and could walk to work. Ms. Salazar was active in her church and on community boards, such as the United Way Board and the local Hispanic youth services agency.

Hence, she appeared to have some important ties with the community. She was respected for her community and church work and was considered an exceptionally bright, creative, and hard working woman.

Ms. Salazar had spent most of her evenings since her daughter's mugging canvassing the neighborhood trying to get support for a community drug prevention program. She talked to some local social service agencies. She also spoke to the local United Way Board to encourage support of Five Corners. Her rationale for why Five Corners was worth saving was "Yes, Five Corners has just begun big-city crime and violence with inner-city spinoff gangs; however, Five Corners is the type of community where a reasonable effort can make a big difference in reducing gang activity, crime, and substance abuse. We haven't lost the war on drugs and crime here, yet."

In her search for existing substance abuse prevention programs, Ms. Salazar found that a group, sponsored by the local health clinic, called "Say Yes To Life," had secured a 3-year grant from the Federal Government. The group no longer operated. Also, she found one drug treatment program in the area, a community mental health center alcohol and drug outpatient clinic on Center Street called "Stay Free." She found two substance abuse programs operated by two different private, nonprofit youth services agencies with Federal funding, but both would end in a year: 1) an inhome case management program for at-risk immigrant Asian families and 2) an afterschool Hispanic youth leadership and skills training program operated in the schools.

After the disappointing first meeting, Ms. Salazar made some telephone calls and discovered that there was no drug abuse prevention specialist within the city government, only in the county government that deals with neighborhoods outside the city boundaries. She was told by the mayor's office that there was a substance abuse prevention specialist working at a community agency who had years of experience and might be willing to help.

The director, eager to cover Federal and State funding that was slated to end in a year and supported about half the agency's staff, assigned a prevention specialist to search for substance abuse funding opportunities and write proposals for new substance abuse and crime bill funds. The assignment was to help local high-risk neighborhoods mobilize to be successful in attracting new funds. The agency would staff the community mobilization or coalition, conduct needs assessments, support interventions, and evaluate the community-based prevention efforts.

Hence, the prevention specialist wanted some access to a likely high-risk community with good potential for successful action as a target for new Federal and State funds. Ms. Salazar asked the specialist to attend the next meeting to advise her group on how to proceed.

Because getting this grant funded to please the new boss was important to his job, the prevention specialist was careful in his initial enthusiasm in helping this particular neighborhood over other neighborhoods. He recommended *an assessment of community readiness* for

prevention programs by collecting some information on community strengths and problems. This information was needed to determine whether this should be the neighborhood selected to target the agency's time and the Federal funds. In addition, the agency was pleased that the group had contacted it because the group's action indicated some grassroots interest and commitment from a neighborhood that had the reputation for having the most drug-related crime in the city.

II. ASSESSMENT OF COMMUNITY READINESS

Using the assessment questions in the NIDA resource manual, *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*, and adding more that were relevant for the community, the prevention specialist helped the community group at its next meeting assess its community's readiness for substance abuse prevention. Seven factors (which spell PREVENT) and the diagnosis are presented below.

1. Problem Definition: *Minimally Present*

Group members asked themselves the following assessment questions:

What is the drug problem and its extent? Who has the problem? Where? Are there existing needs assessments? What are the risk factors that cause this problem to occur, and what protective or resiliency factors could prevent substance abuse? What services exist to prevent drug problems?

Ms. Salazar's committee concluded it had only a vague problem definition based on personal experiences and what was heard in the media. Committee members had heard that drugs, crime, and gangs were the major problems but had little idea of why these problems were increasing dramatically in their neighborhood. They did not know the actual extent of the drug problem, who had the problem, the types of drugs being used, and to what degree. No formal needs assessment had been conducted; there had been no focus groups, key informant interviews, or collection of existing data. Ms. Salazar conducted an informal assessment of existing substance abuse prevention programs by calling some friends and social services agencies and talking with the United Way to determine whether any drug prevention services existed in Five Corners. (Unfortunately, this focus on substance abuse prevention meant that Ms. Salazar missed many existing services for youth and adults related to delinquency, gang prevention, or other youth problems.)

Joe Bennett, a community resident in the group, said that the police had reported at the last community council meeting that the growing crime rates were due to the increasing numbers of homeless people. After discussing this information the group concluded that increasing drug-related crimes were related to the increasing numbers of organized youth gang members moving

into Five Corners. The group felt the families of gang members were moving to Five Corners because the economy was strong and new jobs existed and because of the perception that it was a better place to raise children than other parts of the metropolitan area. Mr. Maniu reported that guns were showing up in the elementary schools. He thought it was because of the new gang families moving into the neighborhood.

Also, Juanita Esperanza and Mali Ng discussed how their children felt increasing discrimination against them in the schools because they were Mexican and Asian respectively. The primary gangs—the Mexican Mafia and the Crips—were of the same ethnic backgrounds. They also were having a difficult time getting their children to go to school. Their high school children reported that teachers had less interest in them ever since the school moved to attract more academically elite students from the district to their college preparatory program. The parents speculated that lack of school attachment and school failure might be primary risk factors in youth related to increased substance abuse and gang organization in the community.

2. Recognition of the Problem by the Community: *Moderately Present*

Group members asked themselves the following community assessment questions:

> Is there a broad awareness of the drug problem? Has any mobilizing event occurred? How much do key leaders support the need for prevention? How much do people in the community discuss the drug problem or link it to crime?

The group decided that there appeared to be recognition of the drug problem by some members of the community but did not know how widespread the recognition was. There had been several major incidents or community events involving drugs that demanded a community response: the mugging of Ms. Salazar's daughter, a shoot-out between rival drug gangs at the bus stop in front of the high school, and the killing of several gang-involved teenagers outside a local rock concert. These incidents were extensively covered by the news media, further increasing the public's perception that the drug and gang problems centered in the Five Corners area.

However, there was little impetus to mobilize to solve these problems until Ms. Salazar and Mr. Maniu organized the group. Most parents of the youths involved in these incidents had talked to the media but had done little more. The two community resident council members had been too busy with other citywide issues to act. The group was somewhat concerned about the community's willingness to act, based on the poor showing at the committee meeting at the Methodist Church. However, members had some hunches about why the community-mobilizing approach taken did not work well for them in this ethnically diverse community: 1) the timing was bad as the holidays were approaching, 2) the location was not neutral (it was an Asian church), and 3) a more personal invitational approach than flyers was needed. They decided to

personally invite members who had access to the talent and resources needed to be successful. Their second meeting was successful: about 80 percent of the key leaders invited to join the committee came and were very committed. A good group dynamic occurred, further enhancing the probability of success.

3. Existence of and Access to Resources: *Moderately Present*

Group members asked themselves the following community assessment questions:

What human resources are available? How much time can they commit? What are their skills? What potential funding exists? What *pro bono* help is available?

Because this was primarily a grassroots citizen group had little knowledge of existing resources, such as services, funding sources, or sources of personnel, paid or unpaid. Ms. Salazar had called several agencies and friends to determine whether a drug prevention program for youth existed in the Five Corners community and conducted an informal key informant survey of prevention services available. Although Ms. Salazar had told the prevention specialist she knew how to write grants, her skill level was unknown. Additional professional support in grantwriting was available from a professor at the university who taught proposal writing and was an expert in substance abuse prevention. She was teaching a grantwriting workshop during the summer for community agencies. The group believed it could find grant writers, program planners, and evaluators in the local community and from several local universities who would work for free if written into the grants. They could help in the grantwriting and needs assessment process. One member of the group told about the student volunteer programs at both the university and community college as a resource to get additional volunteer support. Another person mentioned a university professor who conducted a neighborhood community door-to-door survey of crime and drug problems that could be located and used in the needs assessment.

4. Vision or Plan: *Minimally Present*

Group members asked themselves the following community assessment questions?

Is there a vision? Who has it? How widely is it shared?

Although the group had a vague vision of a safer community, no plan existed except to get substance abuse and crime bill funds to support a community drug prevention program for youth. There was no strategic plan that identified 1) goals and objectives derived from a needs assessment, 2) activities to be undertaken in prioritized and time order, and 3) the source of

resources to implement the activities. It was unknown whether important stakeholders in the community shared the vision of a safer community and believed that a substance abuse prevention program would address this problem effectively.

5. Energy To Mobilize and Sustain Prevention Activities: *Optimally Present*

Group members asked themselves the following community assessment questions:

Is the community motivated and committed to addressing the problem? Are primary stakeholders involved? What benefits can be offered for participation? Are there any barriers? Can the effort be sustained?

In a preliminary meeting, the members of the group systematically invited the needed members to join the committee. These members rounded out the talents needed. Based on the first formal committee meeting, the group appeared to be committed and to have all the talents needed to implement prevention activities. Although it was unknown how long individuals would be able to sustain their active commitment to this effort, a quick assessment of their perceived benefits and costs in participation suggested longevity for the group. The professionals in the group would support the networking with stakeholders and local leader. The prevention specialist increased the contacts with the local community drug prevention coalition run by the county.

6. Networking With Stakeholders: *Optimally Present*

Group members asked the following community assessment questions:

Does the effort have the blessing of key leaders? What other groups could become involved?

Although this group was not directly connected with any agency or organization, it had the support and backing of the mayor's office that assigned a community liaison to work with the group, United Way, and other social service providers. The new committee structure included the key leaders in the schools and community needed to implement prevention programs successfully. The group had no official connection with any existing agencies or stakeholders, but it had connections to powerful community leaders, residents, and businesses through places of employment.

7. Talent; Leadership Structure; Sense of Community: *Optimally Present*

Group members asked the following community assessment questions:

How homogeneous is the community? How stable is it? To what extent do community members share the same values? Does the community have a history of working together?

Although mobility was high, with 50 percent to 85 percent of the children in the elementary schools not returning the next year, most families did not move out of the Five Corners area but relocated to other low-rent apartments within Five Corners. Similarity of the residents was low because of the high number of ethnic groups in the area. However, there still was a strong sense of community and pride in the area. The level of community activism had been demonstrated by the fact that the local community council was one of the most active in the city and had the largest number of residents who participated consistently. Because of strong traditional values held by many residents of Five Corners, there were a number of mothers working in the home caring for their children. They were active in their communities and church activities. The group believed that churches could be a major source of support in the development of the prevention activity.

Community Readiness Assessment Summary and What Is Needed

Three community readiness factors were optimally present: Talent; Leadership Structure; Sense of Community, Energy To Mobilize and Sustain Prevention Activities, and Networking With and Support of Stakeholders; two were moderately present: Recognition of the Problem by Community and Existence of and Access to Resources; and two were minimally present: Problem Definition and Vision and Plan.

Although this community group did not have the time or resources needed to implement prevention programs, the community circumstances were right to help them mobilize to locate good resources. Much would depend on the mobilizing abilities of Ms. Salazar and the group of dedicated citizens.

III. STRATEGIES FOR INCREASING COMMUNITY READINESS

Based on the community assessment discussion at the first preliminary meeting of the committee the group determined irs areas of weakness. At the second meeting it determined what

needed to be done. The group decided that the highest priorities for action were:

- To conduct a *needs assessment*, including reviews of existing needs data, reviewing literature risk and protective factors and processes for substance abuse, and possibly conducting their own community survey of perceptions, attitudes, and current substance use;

- To establish a clear vision by developing a *strategic plan*, including a mission statement, guiding philosophy, goals and objectives, proposed activities, and evaluation strategies;

- To increase *community resources* by identifying potential volunteers with specific kinds of needed skills, locating potential funding sources, and getting support or training in writing proposals; and

- To increase *broad-based awareness* of the substance abuse problem by planning a media campaign and discussing the drug problem and possible solutions with the community council and mayor's office.

1. Conduct a Needs Assessment

The committee decided it would be more efficient to create a Needs Assessment Subcommittee for the collection of existing social, health, and crime statistics. It decided first to contact the university professor who had conducted prior community needs assessments and ask him to staff the committee. Other proposed members included the county prevention specialist, Ms. Salazar, the university substance abuse prevention specialist, a former prevention program social worker, a health statistician from the health maintenance organization, the Volunteers in Service to America (VISTA) volunteer, and the head of the statistics department for the county substance abuse agency and health department. Because of the specialized nature of this committee, the task force had to recruit new data specialists to this subcommittee.

Committee members planned to conduct a search for existing information on the drug problem. They would contact the university professor who did the last volunteer survey and the State and county alcohol and drug abuse services departments for data. They also decided that they wanted to get information directly from residents about their perceptions of the causes of substance abuse in their neighborhood and not rely on external studies. Hence, they planned to design with expert support a face-to-face interview to be conducted in randomly sampled homes by the task force members supplemented by university volunteers working in pairs. They particularly wanted to find data on precursors or causes of substance abuse in high-risk youth to target prevention efforts to reduce those risk factors. Some members of the group said they also

needed to focus on increasing protective factors, such as family stability and support and to increase resilience to drugs and alcohol in youth.

Archival Data

The Needs Assessment Subcommittee met and decided that the first course of action was to assemble as many sources as possible of existing data on the problems in Five Corners. Members developed a data collection plan that listed all possible kinds of data: medical, health, economic, family status, alcohol and drug abuse, crime, delinquency, gangs, and so forth. They then assigned members to collect the data. The head of the subcommittee combined all existing data into a needs assessment section for the strategic plan.

Research Literature on Risk and Protective Factors of Substance Abuse

The committee also worked with the prevention specialist at the university to conduct a review of national literature on what causes substance abuse in youth and adults. Luckily, the university drug prevention specialist professor had collected data on the causes of substance abuse in 1990 on 2,400 high school students in six high schools, including 400 sophomores and juniors at Five Corners High School. These data were analyzed and published as a causal model of substance abuse. Such data created a basis for determining the degree to which peer influence, poor school bonding, low self-esteem, poor family relations, and poor school climate affected substance abuse in the local youth. The data existed for males and females with peer influence being equal for both. However, separate data did not exist for each ethnic group. A separate analysis for Hispanic students suggested that family was a much stronger influence on the Hispanic students than on students in the general population (mainly white).

School Survey

The committee decided that it would like to collect additional data at the high school to determine whether the causes of substance abuse were different in each major ethnic group. The high school assistant principal was supportive and took charge of the project with the university professor who had done the original survey. They planned to conduct the survey of current sophomores, juniors, and seniors as soon as school research committee approval was obtained. The professor said she would supervise the data collection with students and analyze the data free.

Key Informant and Local Citizen Survey

In addition, the committee decided that it needed additional information that did not exist in the social indicators data, such as the perceptions of the community members about the drug problem, why they thought it was increasing, and what they thought could or should be done about it. A standardized questionnaire was created containing these questions, and 20 community

key leaders and 50 local residents were interviewed by telephone concerning these issues. The data were tabulated and presented at the first community meeting.

2. Develop a Strategic Plan

The first draft of the strategic plan was created after the analysis of the needs assessment by the community group with help from the university professor and students. Before groups in the community were formed into task teams to write different sections of the community plan, they attended a training event on promising approaches to prevention and how to develop a strategic plan.

Community Drug Prevention Training Event

To educate the community about the drug problem and promising approaches to drug abuse prevention, a major community event was planned. The local university volunteers reserved their Graduate School of Social Work auditorium, library, and classrooms on a Saturday for the event. The Community Meetings and Events Subcommittee planned the event in conjunction with the Member Training Subcommittee. A National Performance Review Laboratory (NPR-L) grant provided some technical assistance and training funds to hire local and national speakers. A nationally known specialist in risk assessment for substance abuse and his staff conducted training on how to mobilize a community coalition and assess risk factors.

Keynote speakers and breakout session speakers (some local volunteers) discussed the needs assessment and locally and nationally effective approaches. A wide variety of approaches were presented. Task teams already had been created to deal with major constituencies of the group, such as those working with juvenile justice, youth, parents, senior citizens, churches, businesses, schools, higher education, each major ethnic group, alcohol and drug treatment, and the recovering community. Each task team was introduced to a strategic planning model in a plenary session and sent to a breakout session to brainstorm goals, objectives, activities to meet these goals and objectives, and resources needed, including recommended funding sources.

Developing the Strategic Plan

After the training event, six community meetings with the total group were held between November 1994 and June 1995. The meetings were held at Five Corners Middle School. Those attending the strategic planning meetings were mostly residents of the target neighborhood. There was representation from diverse groups in the neighborhood. The meetings produced a Strategic Plan for the Five Corners Community Council that, among other things, identified the strengths, weaknesses, opportunities, and threats in the neighborhood; identified and prioritized key issues; formulated objective statements describing what the groups intended to do; listed goals and action

statements stating how the groups planned to realize their ideas; discussed who was available to help accomplish the goals; and set a schedule for how the goals should be realized.

Reconcile Individual Task Team Plans With a Draft Strategic Plan

Task team plans, typed on standardized forms, were integrated with the strategic plan. Each document was reviewed by the Strategic Planning Committee that met with each task team. Priorities for action were based on funding and facility possibilities, feasibility of the plan, team commitment to action, collaboration among several teams, and total community interest. The priorities from the first community meeting were considered as well as suggestions from focus groups and the key informant needs assessment survey that also included recommendations for action. A few projects with a high likelihood of immediate success were chosen as well as some longer term activities. Grantwriting was clearly needed for many of these plans to attract local, county, State, and Federal funds.

3. Increase Community Resources and Prevention Funds

The group decided after its first meeting that it needed to increase community resources by identifying potential volunteers with specific talents and needed skills. Key players were invited to participate in the committee: representatives from the high school, substance abuse prevention agencies, the mayor's office, the community council, the county substance abuse community coalition, and the police department.

A Funding Development Subcommittee was created and instructed to find potential sources of funding and prepare grant applications. It was successful in writing grants and attracting funds. Ms. Salazar secured a Bureau of Justice Assistance (BJA) Comprehensive Communities grant to create Community Action Teams (CATs) in the neighborhoods, a Family Peace Center, and many community development projects. The university professor and staff wrote a proposal and were awarded one of the five NPR-L grants targeting technical assistance and training for Five Corners in substance abuse and crime prevention. Because of the NPR-L grant award, the community would get priority on many different types of Federal funding. The Center for Substance Abuse Prevention (CSAP) awarded a $50,000 supplemental grant to the County Drug Prevention Coalition to organize a community coalition in Five Corners for substance abuse prevention.

The major's office offered Ms. Salazar a position as director of the comprehensive communities grant. In this new position, she organized a local effort to win the Office of Juvenile Justice Delinquency Prevention (OJJDP) Safe Futures grant. The university professor offered a summer workshop for all Five Corners agencies and citizens who wanted to learn to write grants. About seven grants written by different community agencies were submitted, and three were funded. One was for the Family Investment Centers (FICs) submitted by the Housing Authority of the city to the U.S. Department of Housing and Urban Development (HUD). It was funded

along with a Drug Elimination grant. New drug elimination projects and family and parenting programs began in the housing complexes in Five Corners. The Asian youth services agency also wrote a CSAP grant proposal that was funded to continue its substance abuse prevention efforts with immigrant Asian families. Most important, the county drug prevention specialist wrote a proposal and his community agency was awarded funding from the National Institute of Mental Health (NIMH) to develop a major initiative in Five Corners to reduce family violence and crime related to substance abuse.

The Funding Development Subcommittee also was successful in attracting Weed and Seed site recognition (but no funding). A special meeting was held with all criminal justice personnel in the Five Corners area and several COPS crime bill grants were applied for by and awarded to the police department.

Private funds also were sought by business representatives in the group. A local major businessman in the area was contacted to provide $5 million for a new recreation and community center building in the park. Because this businessman had unsuccessfully urged the university to change its name to his name, he was looking for other community buildings that could be named for him. Based on this new building construction, a new Boys and Girls Club was attracted and is in the process of being developed.

Based on Ms. Salazar's enthusiasm and involvement, the United Way Board raised $1.4 dollars from community businesses and foundations to implement Success by Six, an early intervention project involving home visitors for high-risk pregnant women in the Five Corners neighborhood.

4. Increase Community Awareness

Because area of weakness in the community needs assessment was a broad-based citizen awareness of the substance abuse problem, the committee planned a media campaign and a number of community events,including a multiethnic community festival in the park with ethnic music, dancing, and a potluck dinner; a community resources fair; a National Night Out Against Crime; Red Ribbon Week events or a nonalcohol graduation party at the high school; mocktail contests; a crime and drug watch; graffiti cleanup; a crack house cleanup; neighborhood cleanups; and community gardens.

From the beginning, the residents of Five Corners had been heavily involved in substance abuse prevention, law enforcement, community policing, prevention, early intervention, treatment programs, and neighborhood restoration. Local residents became the driving force behind the effort to develop an ongoing Drug Prevention Coalition for the target neighborhood. After a high school health class project conducted sting operations on local merchants to determine who sold

tobacco or alcohol to minors, the residents mobilized to patronize the merchants who did not. The local newspaper published a list of these merchants and commended them.

In a drug and crime prevention effort, 250 block leaders were trained to organize their neighborhood and teach block watch volunteers how to communicate effectively using mobile telephones. The local National Guard provided the training. A volunteer Mobile Watch Organization was organized to drive through the area nightly in marked vehicles to report possible crime and drug offenses.

IV. MOVING ON

When the community was ready for substance abuse prevention programming, it implemented some specific universal and selective prevention activities, including:

- **School Climate Improvement Projects**. Five Corners High School organized teams of parents, students, staff, teachers, and business members to conduct a needs assessment, prepare a plan, and implement substance abuse prevention projects. Thirty-five universal, selective and indicated projects to improve the school climate for ethnic students and all high-risk students were implemented and resulted in immediate improvements in grades and dropout rates in high-risk students and reduced reports of discrimination.

- **Afterschool Youth Programs** were implemented in the elementary, junior high, and senior high schools involving skills training curriculums, values and drug education, mentoring, tutoring, and recreation. These reduced the number of latchkey children and reduced crime and substance abuse.

- **Parent and Peer Support Groups** were organized in the sixth to seventh grades where classrooms of students and their parents met to discuss developmentally appropriate issues in this difficult preteen stage.

- **Parenting and Family Skills Training Classes** were offered in elementary and in junior high schools, mental health centers, substance abuse treatment programs, and churches. Treatment centers offered the classes only for parents who abused alcohol and drugs to reduce family conflict and improve supervision, discipline, and parent/child relationships.

- **Kids Coalition** was organized, with support of the health department, and was successful in mobilizing and organizing a major letter-writing campaign before and during the State legislative session to raise taxes on tobacco and remove smoking areas from public places.

- **Community Policy and Legislation Change Projects** such as writing legislation and getting local sponsors were started as the community became more sophisticated.

- **Emerging Substance Abuse Issues** in the target neighborhood were addressed by *ad hoc* committees of residents as necessary. For example, a committee was formed to address drug problems in a public housing project in the target neighborhood. A plan was devised to make physical improvements to the project, sponsor motivational activities for residents, and encourage residents to become involved with residents of the target neighborhood. Some local residents volunteered to help colead parenting and family skills training classes in the new Family Investment Centers in the housing complex.

APPENDIX C: PLANNING GUIDE

To complete the planning process, assemble a planning team composed of top leaders and decisionmakers. Solicit input from all levels of the organization and all stakeholders. Ask top decisionmakers (with input from others) to determine the mission and goals. Assign task groups to develop objectives and activities to support achievement of goals.

I. Scanning (Situational Analysis)

Gather as much information as possible about what is going on that might affect the program:

- What problem are you trying to correct? Why is your program needed? Who would benefit by your program?
- Are there other organizations doing the same kind of work? How will you be different?
- Are there other things competing for the time or attention of your target audience? What can your program do to attract the audience away from other interests?
- What is happening politically or legislatively that may affect your program? Are there pending regulations that will affect what you do?
- What changes are occurring in the prevention field that may affect your program?
- What is happening in the community (however you define community) that may affect your success? New models? Technological changes?
- Are there any threats to the program?
- What opportunities are there for strengthening or expanding the program?
- What is occurring in your organization that could affect the program? What are the organization's strengths? Weaknesses?

II. Mission

- What is your purpose? What do you hope to achieve as an organization or program?
- Whom will you serve? (What population? Within what boundaries?)

- What philosophy underlies your program?

- What assumptions underlie your program? (That is, what strategies or approaches do you believe will allow you to realize your vision?)

III. Goals

- What will you have accomplished if you achieve your mission? List all the major things you intend to accomplish. (Be sure to state accomplishments as end results, not as procedures or steps to be taken.)

- What are the priorities among these accomplishments?

- Narrow the list to a manageable size—no more than 8 to 10.

- Be sure to include administrative accomplishments, such as a secure funding base.

IV. Objectives (To be developed by task teams or organizational units)

- For each goal, list all the things that must be accomplished to achieve it. State accomplishments as end results, not procedures or action steps. Prioritize the list.

- For each end result or accomplishment, write a statement as follows:

  — State the desired end result (only one end result);

  — Be sure the end result is realistic, but not too easy to achieve;

  — State any conditions under which the end result must be achieved (e.g., within a certain dollar amount);

  — State the end result in measurable terms, in quantifiable terms. For example, indicate how many people must successfully complete a program, what average score must be achieved on a written objective examination, the percentage of reduction in drug crimes by youth in a certain neighborhood;

  — Indicate the date by which the end result must be achieved.

V. Strategies

For each objective, brainstorm different approaches that can be taken to achieve it. While brainstorming, do not eliminate any ideas. Once all of the ideas have been listed, refine the list by combining similar ideas and eliminate ideas that seem too impractical.

Narrow the list to two or three possible approaches. Compare the possible strategies using the following checklist to determine which one appears to be the most viable.

- Do the resources exist to implement this strategy successfully?
- Can this strategy by implemented in time?
- Will this strategy have the support of top decisionmakers and other stakeholders?
- How costly is this strategy compared to others?
- What obstacles are you likely to encounter? How difficult will it be to overcome them?
- What factors work in favor of this strategy? (Are there any strong advantages to using this strategy over others?)

VI. Action Plan

- For each objective, complete an action plan as follows:
  - — List in sequence all steps that must be taken to accomplish the objective.
  - — Determine who will be responsible for completing each step.
  - — List all resources needed to completed each step.
  - — List the date by which each step needs to be completed to ensure that the objective is met.
- Prepare a timeline or Gantt chart listing the steps and showing when each major milestone will be accomplished.
- Prepare an organization chart and staff loading plan showing which people (volunteers included) will be needed each month for each major objective.

- Prepare a budget broken down by objective and divided by months to show when expenditures will occur.

VII. Logic Model

If required by the funding source or if desired, create a logic model.

NIH Publication No. 97-4111
Printed May 1997